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ABSTRACT

The role of collaborative/shared learning in nursing, midwifery, and visiting nurse education in the United Kingdom was explored to identify the qualities and skills needed by practitioners to work effectively in multiprofessional contexts and establish the fit between the knowledge and skills needed in multiprofessional practice and the teaching and learning occurring in educational preparation. The main data collection activities were as follows: (1) in-depth case studies of 6 multiprofessional teams in different clinical settings; (2) a survey of all U.K. higher education institutions running or planning initial or continuing education courses for health and social care professionals; (3) interviews with 14 trust managers; and (4) interviews with representatives of a sample of professional bodies. The study established a lack of congruence between the knowledge needed to function effectively in multiprofessional teams and most current education provision. A critical need for new models of shared learning was identified. An example model based on the clinical case study material was presented. The following were among the model's key elements: (1) incremental development of communication, teamwork, and other key skills; (2) content that is clinically

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relevant, patient-focused, and case/scenario based; and (3) emphasis on interaction and problem solving. (Contains 20 tables/figures and 120 references.) (MN)

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Shared Learning and Clinical Teamwork: new directions in education for multiprofessional practice

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RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Shared Learning and Clinical Teamwork: new directions in education for multiprofessional practice

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Nick Ross
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University of Brighton, Sussex

London, 1999

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Abbreviations

A&E	Accident and emergency
ASW	Approved social worker
The Board	The English National Board for Nursing, Midwifery and Health Visiting
CA	Care assistant
CAMHS	Child and adolescent mental health service
CCETSW	Central Council for Education and Training in Social Work
CMHT	Community mental health team
CPA	Care Programme Approach
CPN	Community psychiatric nurse
DN	District nurse
DoH	Department of Health
GMC	General Medical Council
GP	General practitioner
HCA	Health care assistant
HDU	High dependency unit
HV	Health visitor
IT	Information technology
NHS	National Health Service
NHSE	National Health Service Executive
NVQ	National Vocational Qualification
OT	Occupational therapist
PAM	Profession allied to medicine
PHCT	Primary health care team
PRDN	Pre-Registration Diploma in Nursing
PT	Physiotherapist
RCT	Randomised controlled trial
SLT	Speech and language therapist
SW	Social worker
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Foreword

The English National Board for Nursing, Midwifery and Health Visiting is delighted to publish this report as the fourteenth in its successful series: *Researching Professional Education.*

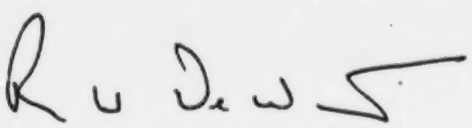
The Board launched this series with the aim of making widely available the results and implications of research commissioned by the Board. The series enables key stakeholders: policy makers, managers, practitioners, researchers and educators to have access to relevant and sound research from which to plan educational developments.

Multiprofessional teamwork and shared learning are an important part of the NHS's move towards community-based and patient-focused care. *Shared Learning and Clinical Teamwork: new directions in education for multiprofessional practice* explores the:

- extent of shared learning among health and social care professions
- factors that influence the roles, functions and scope of professional practice of nurses, midwives and health visitors working in multiprofessional teams
- relationship between learning outcomes and clinical effectiveness in the multiprofessional team
- implications for qualifying and post-qualification education.

The researchers carried out a detailed study including surveys, interviews, and case studies with clinical teams, higher education programme leaders, trust managers and professional bodies.

Their conclusions are of importance to all those who are involved in the development of shared learning and clinical teamwork. The Board will consider the outcomes of the research in relation to policy developments.



Professor Ron De Witt

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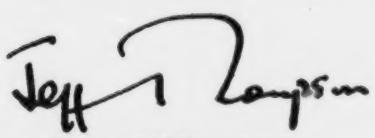

Professor Jeff Thompson

Chair, Research and Development Committee, English National Board for Nursing, Midwifery and Health Visiting

London, 1999

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Key points

- Improved integration of health care provision has been called for by the Government.
- The move in the NHS towards more community-based and patient-focused care has emphasised the need for flexible, well co-ordinated multiprofessional teams, supported by shared learning.
- Programmes of education which include shared learning initiatives have become increasingly common over the past decade.
- The research project aimed to examine: shared learning initiatives in higher education; the skills and qualities involved in multiprofessional working in health and social care; and to consider the fit between the preparation of students and current multiprofessional practice.
- Consideration of the different agendas of the stakeholders in shared learning provision was central to the research.

1.1 Introduction

Over the past decade, successive governments have called for health and social care professionals to work together more closely for the benefit of the patients or clients who use the National Health Service (NHS). The importance of a multiprofessional approach to health care is emphasised, in which all professionals who contribute to a patient's care work not just alongside each other, but 'interprofessionally', as a team; the aim is to provide a 'seamless service' for its users (Griffiths, 1988; DoH, 1989). This means that patients can move between hospital and community without gaps or stumbling blocks in communication about their needs; where the different people caring for them are well informed about other carers' interventions; and where there is an agreed plan for their future care.

To underpin this approach, the Government's education and training directives have highlighted the need for more shared learning between the health and social care professions. The argument is that those who learn together will work together more readily than if they had learned in separate professional groups, and consequently will deliver better total care.

The number of shared learning initiatives for professionals in community-based health and social care has increased over the past 10 years (Barr and Waterton, 1996) and many long-time advocates believe that shared learning is the way forward. If it is set to expand further, this is an opportune time to examine what the initiatives offer and to ask whether they are helping health and social care professionals to work together.

In February 1996, the English National Board for Nursing, Midwifery and Health Visiting (the Board) commissioned a three-year research project in which these and broader questions were addressed. The research had four key aims:

- to map the extent of collaborative/shared learning within and between the health and social care professions, in both theory and practice at pre- and post-registration level
- to analyse the factors influencing the range of roles, functions, and scope of professional practice of nurses, midwives and health visitors within multiprofessional/multi-agency teams in the context of integrated patient care

- to evaluate outcomes of learning from formal education and professional experience in relation to clinical effectiveness in the multiprofessional team
- to identify the implications of the above for pre- and post-registration education.

1.2 The approach to the research problem

Several different groups have an interest in multiprofessional work and shared learning: patients, carers, clinicians, educators, managers, professional bodies and the Department of Health (DoH). These stakeholders each have their own areas of expertise, their own 'language' and understanding of the problems. One of the first questions was to consider how far people within these interest groups would agree or differ in how they saw the issues around multiprofessional teamwork and shared learning.

Multiprofessional work and education have been influenced by a range of factors, including Government changes to the organisation of health care and higher education, changes in some professional roles, advances in treatments and the needs of an ageing population. The various interest groups will see the advantages and disadvantages of enhancing multiprofessional work and underpinning it with shared learning, from their own perspectives and within the context of their own organisational, financial and professional constraints. For example, some factors contributing to current consideration of the role of multiprofessional teamwork in the NHS, such as continuity of care, are different from those affecting educational institutions, such as greater flexibility of programme provision to a wider field of students. Given the potential for differences in the driving forces behind shared learning initiatives and the rapid rate of change in both sectors, it would be easy to see that the developments in the NHS could become out of tune with those in education. From the student's perspective, a new kind of theory practice gap could be created, particularly as developments in multiprofessional education move towards pre-qualifying level. This would be a gap between the reality of multiprofessional teamwork in different types of teams and shared learning education.

The researchers concluded that a key element of the research should be to study a variety of teams that students (both pre- and post-qualification) could find themselves working in and to define and analyse key aspects of multiprofessional team function. This would be done alongside an examination of the content and organisation of shared learning initiatives. Thus, rather than attempting to evaluate the outcomes of specific higher education initiatives in clinical practice, the research sought to direct attention to the prior question of what was happening in multiprofessional teamwork that students might need to learn about. As part of this, the research team expected to throw some light on how teamwork affected patient care; it cannot be assumed that multiprofessional teamwork improves care, as the evidence base is still being accrued. Yet if pre- and post-qualification students and staff are to be educated to enhance their interprofessional abilities, they will need to view the results in terms of value to patient care. Thus a number of research questions were asked.

- What qualities and skills are needed by practitioners to work effectively in a multiprofessional context?
- How do people interpret 'shared learning' in the curriculum?
- If shared learning is to prepare practitioners to work effectively in a multiprofessional context, do shared learning programmes address what students need to understand to function effectively in a multiprofessional team: what is the *fit* between the qualities and skills needed in practice, and the teaching and learning which takes place? What is the influence of learning to work together *outside* the formal curriculum?
- Professional roles have been evolving, particularly in nursing, but also in other professions; how are changes in the boundaries between roles viewed by the bodies which oversee professional standards?

To gather information on these questions, the research team collected material from four sources.

- Intensive study of six multiprofessional teams, caring for patients with different needs, in hospitals and in the community. Each team was observed and its members were interviewed, over a three-month period.
- Surveys of higher educational institutions to discover if there was any shared learning between students in health and social care in their curricula. Initiatives reported were followed up by: a questionnaire to find out more about them; telephone interviews with programme leaders of a sample of initiatives; and visits to observe and interview staff and students in a further sample.
- Interviews with managers in NHS trusts to discuss their views of multiprofessional work and education to support it.
- Interviews with representatives of professional bodies to discuss their views about developments in professional roles and learning between different professions.

Before discussing the research in more detail, some of the key changes and developments in the NHS and in higher education which have contributed to raising the profile of multiprofessional working and shared learning in recent years are reviewed.

1.3 The context of multiprofessional practice and shared learning

The enhancement of multiprofessional teamwork and the development of multiprofessional education have risen up the agendas of NHS management and universities in the last decade. The main reasons can be traced to the effects of the recent changes in the delivery of care in the NHS and the implications of those changes for education and the professions.

1.3.1 Recent changes in the NHS

The growth and complexity of health and welfare services in recent years, and the escalating costs and increasing demands for services as the population ages, provided the impetus for the previous Government to urge rationalisation of resources, reduction of duplication and the provision of a more effectively integrated service. The legislation (DoH, 1990) which created independent hospital trusts, general practitioner (GP) fund-holders and community trusts, each responsible for working within fixed – and increasingly overdrawn – budgets, and more recently, one-tier practice led by primary care groups (DoH, 1997), has produced radical changes in the organisation and delivery of care, including:

- Moves to reduce the number of different health care professionals in contact with patients. These can be seen in initiatives such as 'integrated patient care' or 'patient-focused care' (e.g. Garside, 1993), which aim to give patients a more efficient service, with increased continuity through delivery of care by smaller teams of professionals. Consequently, within the reduced team, knowledge of each other's role and function becomes even more important.
- Emphasis on evidence-based care has encouraged the development and implementation of guidelines for good practice in managing a wide range of conditions in primary and secondary health care. The effective use of the guidelines and development of 'patient pathways' require co-ordination and communication between the health and social care professionals drawing up and operating the pathways.
- The Patient's Charter, which contributes to raised patient expectations about the quality of service they can expect from the professionals who care for them.

- The introduction by some trusts of multiskilling of health care workers with a consequent overlap of interprofessional boundaries. This creates both opportunities for professional development and threats to professional integrity.
- The changing role of nurses, including the delegation of some work to health care assistants, the take-up of some work formerly carried out by junior doctors, and the advent of nurse practitioners.
- New surgical techniques and the emphasis on care in the community which have resulted in earlier discharge of patients from hospital. This places even more emphasis on good liaison between primary and secondary health carers. A number of these patients continue to require specialised care from a range of professionals, so the development of skills, including good team working and communication, is seen as essential.

The moves to increase care in the community and the greater emphasis on interprofessional and inter-agency working have considerable implications for the integrated management of services as well as the roles of practitioners. For example, the report of the Sainsbury Centre for Mental Health states that:

> *'We believe that the transition from hospital based to community based services needs comprehensive changes in staff roles as well as in the structure and organisation of services.'* (Onyett, 1997: 23)

The report indicated some of the disquiet accompanying role changes:

> *'Other submissions to the review provided further evidence of the preoccupation with multi-disciplinary working by the professions and high levels of professional disquiet about changing roles are evident from all of the evidence considered. In many submissions, role blurring was linked to fears of de-skilling.'* (Onyett, 1997: 55)

Concerns about deskilling and that multiskilling also means dilution of skills are being expressed in a context of chronic shortage of staff, particularly nurses, but also professionals allied to medicine (PAMs) and GPs. Current problems in staff recruitment and retention have brought multiskilling even more to the fore over the last three years. Management of the NHS is having to consider how to meet a range of patient needs with fewer staff. Issues of role flexibility thus become a necessity rather than a virtue, with all the associated professional concerns. This is taking place amidst concerns about accountability in a climate of defensive medicine and the introduction of clinical governance (DoH, 1997; 1998).

1.3.2 The NHS Executive's guidance to purchasers and providers of education

The Government White Paper *The Health of the Nation* (Secretary of State for Health, 1992), pointed to the need for partnerships between individuals and organisations for the improvement of health care. *Targeting Practice: The contribution of nurses, midwives and health visitors* (DoH, 1993), focused on alliances to provide multidisciplinary solutions, supported by multidisciplinary education.

During the last four years, the NHS Executive's (NHSE) education and training planning guidance has consistently emphasised shared learning and multidisciplinary teamwork. For example, its 1995 planning guidance stated that:

> *'Education commissioners should actively explore opportunities to commission multidisciplinary education and training programmes which provide opportunities for shared learning.'*
> (EL(95) 96 August 1995, Priority 5 [non-medical education and training])

The following year, Priority 5 remained an important medium term goal, and the guidelines acknowledged progress being made in primary care and mental health, but also commented that:

> *'Reports from the Health Service Commissioner about team working, especially around the boundaries of health and social care but also elsewhere, point to the need for further work to improve collaborative team working and mutual understanding of roles, responsibilities and expertise amongst health professionals.'* (EL(96) 46 17 June 1996, Annex B: 6)

The responsibility for planning and commissioning education and training in the NHS began to be devolved from regional health authorities to local education consortia from 1996. In June 1997, the NHSE further defined the future work of the consortia to include promoting:

> *'... shared learning to support team-working across professional and organisational boundaries, preparing the health care workforce to provide a coherent service within a primary care led NHS and across health and social care boundaries.'* (EL(97) / 30), point 19)

The NHSE's planning guidance also contributed two other points relevant to shared learning, which appear to be directed at professional bodies. These concern professional qualifications and a common language in occupational standards. First, the assurance that in advocating shared learning, no 'threat to existing professional qualifications or to independent self regulation' was implied. Second, that the NHSE:

> *'... encourages statutory and professional bodies to explore the integration and use of occupational standards within new and existing health professional educational programmes. This approach can assist in creating an explicit 'common language' for the expression of individual and multiprofessional competencies; improving links between academic, vocational and professional structures and enhancing access routes into professional education.'* (EL(96) 46 17 June 1996, Annex B: 6)

These guidelines were not directed at dental and medical education.

The messages are clear: commission shared learning, improve and support multiprofessional teamwork, create a common language to facilitate integration of standards and transfer across qualification boundaries.

The constellation of factors which led to the delivery of these messages at this particular time would make an interesting study in itself. Greater cost efficiency in workforce planning as the NHS struggles to meet the demands on it suggests one factor. In advancing the value of multiprofessional teamwork, the NHSE could not at present be said to be relying on evidence-based advocacy. Teamwork in health care has a long history, but as Leathard (1994) maintained, there has been little research evidence to substantiate the view that collaboration leads to improved quality of care which has furthered the well-being of patients. Evidence is gradually building up (e.g. Tope, 1998), but while co-ordination is generally accepted as a valuable goal, it is difficult to assess its outcomes. In their review of teamworking in primary health care, West and Slater (1996) commented that methods of measuring its effectiveness are not well developed and that this must be addressed if the contribution of teamwork is to be properly evaluated.

1.3.3 Changes in the organisation of education

Before this NHSE recent guidance, a report from the Centre for the Advancement of Inter-professional Education (Barr and Waterton, 1996) indicated a rise from 1990 in the number of shared learning initiatives in primary and community care offered by educational institutions and health and local authorities for the health and social care professions. The numbers rose rapidly, from 1992, and three quarters were post-qualifying (Figure 1.1). During

this period of development, all schools of nursing have been integrated into universities to join other health and social care professions, such as social work, health visiting, physiotherapy, occupational therapy and podiatry. The role of consortia in purchasing education has implications for quality, relevance and cost. As in the NHS, much of the impetus for change in these educational institutions has related to financial efficiency. In a competitive market, the increased number of students resulting from the addition of nursing has increased the concern to avoid unnecessary duplication of the planning and provision of teaching and to make cost savings.

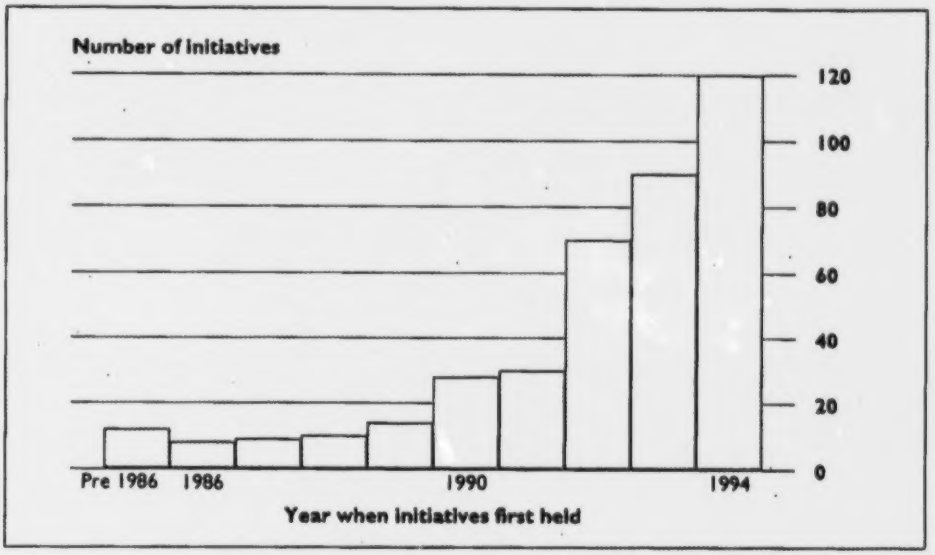

Figure 1.1: The rise in shared learning initiatives in primary care, 1986-1994 (Barr and Waterton, 1996)

With the potential for yearly fluctuations in contracted student numbers, educational institutions have identified the value of a flexible, modular system, enabling programme components to be shared between health care disciplines. This has the advantage that dips in local need for students in one profession may be compensated for by increased numbers in another. Teaching staff can be employed to provide input on a range of modules, rather than depending on one main programme or contract. If offering multiprofessional education modules can provide the flexibility and efficiency the educational institutions need to achieve, while still attracting students and meeting the NHSE's directives, this would appear to provide a good solution.

However, the driving forces in programme development promoting shared learning which might meet strategic planning targets may not match the interests of the NHS. Curriculum developers need to be convinced of the necessity of giving a central place to knowledge about multiprofessional practice in their curriculum design in preference to offering elements of existing academic programmes or modules which are deemed, by their apparent generalisability, to be suitable for sharing. Larger groups, being taught together can also mean that there is little interaction between them, and their learning experience might more appropriately be called 'common learning' rather than shared learning. The present research project examines both the impetus behind the development of shared learning initiatives and the kind of interaction between students from different health care disciplines in their shared learning curriculum.

1.4 Guidance from the professional bodies

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, 1992) endorsed the term 'shared learning', supporting it in principle within the context of professional practice. Such learning was seen to increase the scope for collaboration

and co-operation in care; increase the level of understanding between members of the care team; and increase cost-effectiveness in the development of skills common to more than one discipline.

The Board and the Central Council for Education and Training in Social Work published a joint strategy for shared learning (ENB and CCETSW, 1992) which pointed to the desire of health care consumers to receive integrated services to meet their needs rather than being prey to professional boundary maintenance.

The Standing Committee on Post-graduate Medical and Dental Education has produced a working paper for consultation on multiprofessional working and learning (SCOPME, 1997) and a final report with recommendations in 1999. The working paper was based on consultations and written evidence across a number of health professions. It presented views on organisational and education contexts for multiprofessional learning, which it says has:

> *'... entered a new phase which is about preparing practitioners to operate within a multiprofessional context in the clinical environment. This approach requires a new set of skills centering on how professionals interact with one another in the clinical environment ... how professionals form teams, how they plan together and make decisions together within the clinical context.'* (SCOPME, 1997: 15)

This paper makes a specific point about the skills required to operate in a multiprofessional team, citing forming teams, planning and decision-making, as distinct from theoretical knowledge. It concludes with the view that:

> *'... the time is now right for some principles to embed a multiprofessional approach into systems for health care delivery and medical and dental education.'* (SCOPME, 1997: 17)

In the final report (SCOPME, 1999) it is interesting to note, in view of these earlier statements, that skills training is not needed:

> *'A skills training approach in team-working is neither necessary nor appropriate. If individuals are provided with autonomy and a climate of equity and mutual respect between different professions is created, then a multiprofessional group will develop its own ways of working and learning effectively together.'* (SCOPME, 1999: 11)

Before developing detailed suggestions about how such principles could be implemented, the paper refers again to the need for practical examples of the experiences of multiprofessional working. The present research, in examining roles and functions within the team, provides some such examples.

1.5 Overview of the report

Chapter 2 discusses the range of definitions of multiprofessional working and shared learning and examines the literature on teamwork and its relevance to working in the changing environment of the current and future NHS. It ends with details of the methodology of the research. Subsequent chapters present different kinds of data to illuminate different perspectives on multiprofessional practice and shared learning. Chapter 3 gives the views of a sample of trust managers about the imperatives they see in managing multiprofessional practice and the role of shared learning. Chapter 4 comprises a clinical case study of multiprofessional working to set the scene for integrated teamwork. Chapters 5, 6, and 7 focus on an analysis of the work of clinical teams, drawing out the implications for education. These implications are further considered in terms of shared learning, from 'novice to expert' in Chapter 8.

Chapter 9 presents an analysis of data from higher education about shared learning initiatives, examines the barriers, and questions how far the initiatives are meeting the needs identified in the analysis of multiprofessional practice. Chapter 10 gives proposals for the emphasis which shared learning curricula might take in order to enhance their congruence with the needs of practice. Chapter 11 discusses the advantages and disadvantages of multiprofessional supervision of students, drawing on data from a case study of an initiative in Finland. Finally, Chapter 12 summarises the key points from the research and considers the implications of the development of shared learning.

Key points

- A number of terms are used to describe multiprofessional working, and working 'together' may imply a wide range of types of collaboration.
- Characteristics of successful teams can include a clear central purpose, understanding of others, communication, flexibility and means of conflict resolution.
- The nurse's role in the team has historically been shown to be dominated by the medical model, but there are signs that this is changing.
- The research used a multimethod illuminative and case study approach to gather data about clinical teamworking, higher education shared learning programmes, and the views of managers and professional bodies.

2.1 Definitions

Multiprofessional

The terms 'multiprofessional', 'multidisciplinary', 'interdisciplinary' and 'interprofessional' team are frequently used interchangeably, but may be ascribed different definitions (Temkin-Greener, 1983; Leathard, 1994). A distinction has been made between 'multi' as being composed of many who may not interact, and 'inter' which implies interaction between members (e.g. Luszki, 1958; Petrie, 1976). Different 'disciplines' may also be referred to within the same profession, meaning different branches or specialisms.

This report refers to multiprofessional teams as being composed of members of different health and social care professions; the nature of their interaction is the subject of the research. However, in reporting data from teams where members use 'multidisciplinary' their terminology is retained. Similarly, in quotes from the literature, the terms used by the authors are retained.

Shared learning

In 'shared learning' at pre-qualification level, participants follow monoprofessional programmes of education but come together with students studying for other qualifications for part of their education. When participants are already qualified, all or part of their continuing learning may be shared with other professions. In 'joint training' the education of different professionals is integrated throughout their learning provision, and was not included in this research.

In pre-qualification shared learning, Shaw (1995) argues that unless learning is purposively interactive, changes in students' attitudes to other professions will not occur. If, for example, shared learning aims to provide a common knowledge base, this does not necessarily enable different professions to work together or understand how others see their roles.

Gill and Ling (1995) distinguish between different types of knowledge entailed in shared learning:

- the interactive experience of learning with others (the process)
- knowledge about the work, roles and responsibilities of others
- knowledge focused on the skills and strategies for collaboration.

They discuss ways in which these may be combined:

- models of learning in which students learn separately about what other professions do

- models in which there is a shared learning process but no focus on strategies for interprofessional collaboration
- models in which learning is interactive and the learning includes ways of collaboration in practice.

The question of what is being 'shared' by students who are learning together, in a variety of contexts, was a key element of the present research. As with all curricula, the stated intentions must not be confused with what actually happens.

Team

What distinguishes a team from a group of individuals? There is the apparently straightforward definition of *'a group of people working together towards a common goal'*. However, this is not clear cut: some people work together with the same goal but do not describe themselves as a team. Others are clearly identified by themselves and other professionals (but perhaps not patients) as teams, such as crash teams and diabetic teams.

There is also the meaning of 'work together'; people may be designated as a team but work independently some or all of the time. When they do work 'together' that may be one after the other, in parallel, interactively or in combinations of these.

Another dimension is the areas of work in which they 'work together'. Are these around tasks or decisions? If collaboration is in decision-making, what weight is given to the contributions of different members? These questions only begin to unpack the multidimensional nature of teamwork illustrated in Table 2.1.

Team
Designated as a 'team' but may work as individuals or together
Not designated as a team but may work together
Work together may mean
Work independently in sequence
Work independently in parallel
Work collaboratively in sequence (i.e. separately but each member feeds back to the next at the end of their input)
Work collaboratively in parallel (separately but feedback *en route*)
Work interactively some of the time
Work interactively all the time
Collaborative work
Tasks
Decision-making contribution (input of different members may have different weight)

Table 2.1: The multidimensional nature of teamwork

Another area of complexity is the variety in types of teams. A clinical area may have the nursing team, medical team, ward team – which consists of nurses, nursing auxiliaries, domestics, housekeeping staff, ward clerks – clinical team, ward round team, management team, community liaison team, student team and others such as physiotherapists (PTs) or dietitians. These teams have overlapping membership, and allegiances may be strained as members are 'expected' by different teams to be in two places at once.

A further dimension is the definition of who is in the team; the answer depends on who is being asked. Perceptions of team membership and the perceived centrality of different members can vary considerably.

A great deal has been written about teams and teamworking. Much applies to teams set up to focus on a specific problem or task, rather than the ongoing and less clear-cut nature of teamwork in the NHS, and can be difficult to apply to current clinical work. Teamwork in primary care has been extensively documented (e.g. Øvretveit, 1990; 1993; 1995; Pritchard and Pritchard, 1994; West and Pillinger, 1996; West and Slater, 1996).

Mandy (1996), reviewing the characteristics of successful interdisciplinary teams, draws on Clark et al. (1986) to select five main attributes:

- **Goal directedness:** a central purpose, a clear, recognisable idea which serves as a central focus for the work (Petrie, 1976), which is embodied in a concept or model transcending disciplinary boundaries.
  In a health care team, members come together to promote patients' health. However, the role of care may be very different in the minds of team members, so that evolving a model that transcends disciplinary boundaries, the patient and their problems can be challenging.
- **Disciplinary articulation:** all members understanding each other's role and recognising areas of overlap within the traditional disciplines.
  Hilton (1995) suggests that this is one of the main areas for education to address to combat fragmentation and isolation within interprofessional work.
- **Communication:** appreciating how other disciplines understand knowledge and the methods by which it is gained and used. If members do not understand each other's 'cognitive map' they will not understand how others interpret the same phenomenon differently.
  Besides differences in language used by different professions, the same terms may be interpreted differently (Pietroni, 1991).
- **Flexibility:** to include valuing different perspectives, accepting changes in authority and status and willingness to take on challenges.
  The influence of status differences between nurses and doctors has long been recognised; the management of such differences can be crucial in productive teamwork.
- **Conflict resolution:** this can include understanding the difference between accountability and responsibility of different team members and knowing what is expected of them (McKenna, 1981).
  Sands et al. (1990) argue that when a common value base, language and conceptual framework are established, the team may see conflict as an opportunity for growth and integration.

Such examples identify important characteristics of successful and less successful teams, but do not address how they can be attained. Reviewing teamwork in health care, Embling (1995) concluded that while 'multidisciplinary teamwork' is a well-accepted strategy:

> *'Recent management and health care literature presents a positive picture of teamwork, yet [this] often seems difficult to achieve in practice.'*
> (Embling, 1995: 144)

Embling identifies potential barriers to effective teamwork as problems of leadership, decision-making and team membership, concluding that:

> *'Understanding key teamwork issues may be an important first step for health care teams who wish to improve their performance.'*
> (Embling, 1995: 144)

However, measuring improvements in performance is complex. West and Slater (1996) comment on evaluating teamwork effectiveness in primary health care:

> *'Teams can be seen as more or less effective depending on the criteria adopted. Consequently, the assessment of team effectiveness has come to be seen as a political as much as an empirical process.'* (West and Slater, 1996: 26)

Views of teams' effectiveness relate to expectations about teamwork. These vary not only among individuals but according to their professional role. For example, Temkin-Greener (1983) suggested that views and expectations are different between doctors and nurses because of the different values and norms of medicine and nursing:

> *'Team care, therefore, may be more accurately termed an intercultural rather than an interprofessional venture.'* (Temkin-Greener, 1983: 642)

Temkin-Greener interviewed senior heads of nursing and medicine in a teaching hospital, and concluded that:

> *'On the individual level, physicians see nurses as extenders of their roles and as helpers. Nurses on the other hand, view a team as providing access to direct patient care, and as a means to gain status. On the overall professional level, medicine's goal is to maintain authority over health care delivery while relegating some tasks to other providers ... The overall professional goal of nursing is to gain a share of authority and to improve the status of the profession.'* (Temkin-Greener, 1983: 654-655)

On the basis of this analysis:

> *'Teamwork is a political problem where nursing demands a share of professional authority and medicine will not relinquish it.'*
> (Temkin-Greener, 1983: 648)

Does this imply an ever-present dissonance or is this view outdated? While the literature repeatedly reports that much about the situation remains the same, evidence of change has been identified.

Nurses' role in the multiprofessional team has important historical and social antecedents, which some authors have argued are the key to understanding its development. The dominance of medicine over nursing has been traced through the history of women's and men's roles in health. For example, Colliere (1986) traced how cure and treatment became associated with written knowledge and the technical skills of medicine; care, associated with women's work, depended on unwritten knowledge and was difficult to appraise and value financially. Corner (1996) argues that such dominance made much of nurses' therapeutic role invisible, and defined illness in terms of medical management. The rise in medical knowledge and technology led to the view that 'getting better' and maintaining good health is essentially dependent on the interventions of doctors; nurses simply carry out orders.

Many studies seem to support that view (notwithstanding the role of senior nurses in guiding junior doctors). One line of enquiry has been the study of communication and decision-making during the ward round. The dominance of medical staff over nurses and other team members has been shown consistently (Sanson-Fisher et al., 1979; Fewtrell and Toms, 1985; Mallik, 1992; Whale, 1993). Busby and Gilchrist (1992) comment on nurses' lack of assertiveness and the *'dominance of medical staff who acted as the central focus for all discussion'*. Social interaction between doctors and nurses in the working environment has been described as a *'game they play'* to avoid confronting inequalities in power and status (Stein, 1967; Tellis-Nayak, 1984). Wicks (1998) explored the effects of hierarchy and power differences in Australian doctors and nurses: nurses constructed methods of circumventing clashes with doctors by getting management on side and obtaining nursing consensus. Stacey (1992) argued that doctors need to relinquish the one-to-one relationship with patients, recognise the contribution of others, including the patient, and adjust notions of clinical autonomy, control over allied professions and doctors' exclusive right to sit in judgement over other doctors.

However, recent research is beginning to signal a change (Stein et al., 1990; Porter, 1991). Nurses are more questioning and able to negotiate with doctors in decision-making (Svensson, 1996). Social, educational and demographic changes have been cited as leading to a change in the relationship (Mackay, 1993; Walby and Greenwell, 1994). Factors such as emphasis in nurse education upon autonomy and critical thinking may be significant; and holistic models of care are more appropriate to the care of the increasing proportion of elderly people with chronic illnesses, and emphasise social aspects of care. Organisational changes in hospitals, the nursing process, primary nursing and the advent of nurse specialists have all contributed to this changing climate.

Svensson's (1996) research was based on interviews in five hospitals with 45 nurses and ward sisters about their interaction with doctors. He points out the value there would have been in following these with observation of their actual behaviour. In the present research study, the value of seeing nurses in action within the multiprofessional team as well as talking to them has been confirmed.

2.2 Methodology

Data were collected from four sources:

- **Clinical teams:** case study data about working in multiprofessional teams in different settings, which could inform education for teamwork.
- **Higher education:** surveys, telephone interviews and visits to institutions to collect data about the development, content and process of shared learning programmes.
- **Trust managers:** the views of managers about multiprofessional shared learning.
- **Professional bodies:** the views of representatives of a range of professional bodies about developments and opportunities for shared learning in health and social care.

The research was observing a developing situation, in which the views and experiences of the individuals involved formed the essential part of the data. The methodological approach was based on illuminative evaluation and research (Miller and Parlett, 1974; Miller, 1983; Parlett and Dearden, 1977), and case study (Simons, 1980; Merriam, 1988). Illuminative research is designed to take account of the context in which people learn and work; individuals' experiences and perceptions within that context; and the value given to those being researched. In multiprofessional work, individuals in one profession and across different professions will see their work from their own perspectives. Discovering these perspectives was a key concern.

The five main principles of illuminative research (Miller and Parlett, 1974) are well suited to a multiprofessional context; the research should be:

- **Problem-centred:** beginning with issues and concerns as defined in real life settings. The 'problem' does not necessarily mean a puzzle or difficulty; it may be a general interest in particular aspects of the context, such as how a particular role is seen and enacted.
- **Practitioner-orientated:** concerned with questions relevant to people involved in practice as opposed to generating questions only of interest to other researchers. The language used must be accessible to practitioners from different professions if the findings are genuinely to communicate with them.
- **Cross-disciplinary:** methods should be determined by the problem, not by the methodology of a particular discipline, such as psychological testing.
- **Variety of methods:** if the problem determines the choice of methods, and depends on the setting and practitioners, the methods are accordingly responsive and flexible. Triangulation of methods is used (Webb et al., 1966), in which accuracy is enhanced at the intersection of the data 'sight lines' produced by each method. Interviews and observations take a central place because of the importance of individuals' experiences and perceptions.

- **Heuristically organised:** the researcher does not pre-specify how the research will develop because the concerns, interests and perspectives of those being researched shape the direction as the study proceeds. This is in line with responding to the concerns of the practitioner rather than to the needs of the researcher with a predetermined plan. Being flexible does not mean losing sight of the goals of the research, and the researcher maintains a degree of independence to remain in control of the research.

Three propositions underlie the illuminative approach. First, there is a difference between intentions and actual practice, and therefore a need to study both; furthermore, the recipients of the action, whether patients or students, may perceive neither the intentions nor the actions in the way that those carrying them out would expect. Second, the links between aspects of the studied setting need to be explored: a single act cannot be understood unless it is located functionally within a pattern of events. Third, historical and evolutionary differences affect the judgements of people within different settings and must be accounted for. This last point was particularly relevant in the case studies of some teams.

2.3 Data analysis

The theoretical basis for data analysis in the methodological approach is grounded theory, in which theories are derived from data rather than data gathering being undertaken in order to test a theory (Glaser and Strauss, 1965; 1967; Strauss and Corbin, 1990).

The process of generating the theory is described as the constant comparative method, based on theoretical sampling, whereby the researcher *'collects, codes and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges'* (Glaser and Strauss, 1967: 45).

Data from both higher education and the clinical case studies were analysed first by listing topic areas raised by interviewees about their work and noting the illustrations of these topics among observations of practice. The views of different people in each sample were compared for similarities and differences. From the topic areas which emerged, the researchers *'progressively focused'* (Parlett and Hamilton, 1972) on areas which illuminated key features of the multiprofessional teams in action. Discussions of the data by the research team brought out themes from the cases and raised further questions to pursue from observations and interviews. Themes were illustrated with quotations from the teams and scenarios from the observations.

Grounded theory is derived from (case study) data which in turn is grounded in the researcher's ways of perceiving the world. He or she can attempt to be as explicit as possible about these, to be reflexive about the background assumptions made in producing the data and deriving theory from it. This recognises the researcher's role as interpreter. In this context, the research team had no preconceived views about shared learning. Nor did the researchers assume that teamwork was necessarily a good thing; however they have a bias towards a positive view of the value of education in improving practice and a commitment to generate model(s) to take this forward.

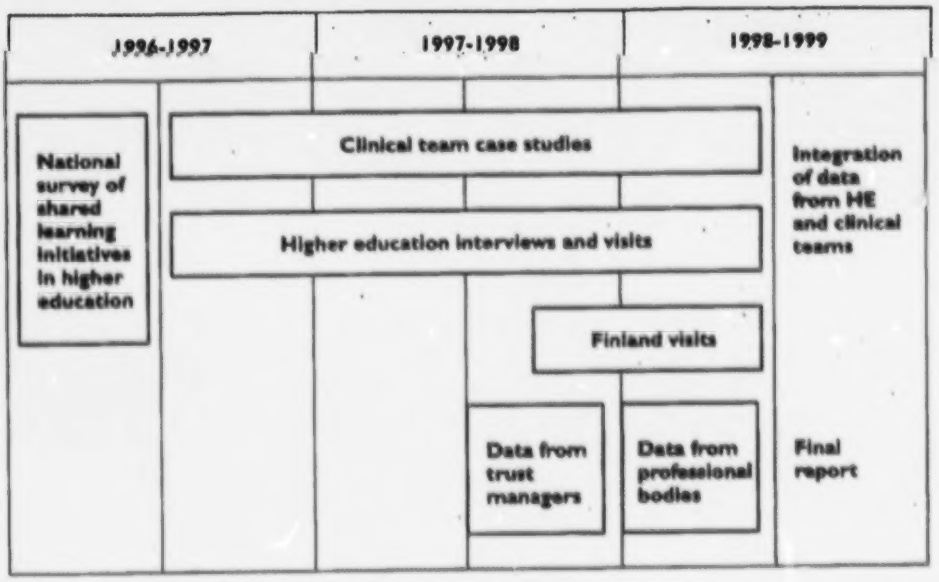

Table 2.2: Sequence of the research

2.4 The sources of data

2.4.1 Case studies of clinical teams

Case studies share many of the principles outlined in Section 2.2 for the conduct of illuminative research and evaluation in documenting the experience of participants and issues in context, attention to diversity of perspectives, openness of design, and progressive analysis of issues. However, case study research gives greater prominence to the nature of the case itself, and what makes it different from the other cases of a similar kind. This project included six multiprofessional clinical teams, in different clinical settings, studied in depth for three months each:

- Case 1: a diabetes centre attached to a general hospital
- Case 2: a non-fundholding general practice (part of a local commissioning forum)
- Case 3: a medical ward in a general hospital
- Case 4: a neuro-rehabilitation centre with a national reputation and an apparently total commitment to multiprofessional teamworking
- Case 5: a community mental health team
- Case 6: a development and assessment centre for children with learning difficulties; this case addressed the field of learning disabilities and provided a community focus, since children were mainly cared for at home.

The choice of clinical areas was based upon five factors:

1. Professional mix: the knowledge that patients would have several other professionals, besides nurses and doctors, contributing to their care.
2. Diversity of context: different settings were chosen to include examples from hospital, community and those which linked both settings.
3. Range of type of patient: to include adult, paediatric, mental health and learning disability. Midwifery and health visiting were represented to some extent in the community-focused case studies.

4. National reputation: the neuro-rehabilitation team had a reputation for multiprofessional care and was chosen to study what that meant in practice.
5. Cross organisation: evidence of team function across organisations in addition to between professionals. Cases 4, 5 and 6 provided such examples.

The teams were based across southern England; given the focus on interprofessional team activity, geographical spread was not considered to be a key variable.

Boundaries of the case study teams

A team's membership and boundaries are variously defined by those who see themselves as members and those associated with it. The research aimed to discover how the idea of a team was perceived by different people. As discussed in Chapter 1, clinicians may be members of several teams; people outside the immediate team may have considerable impact on members' work and are therefore significant (e.g. managers and senior clinicians).

The research began by identifying team members who had contact with patients; interviews and observations extended as other members and contacts were identified.

Are the teams representative?

There may be no such thing as a typical team; the professional mix may be different for different clinical problems, and teams represented by the same professions will vary in how and where they work together. The aim was to present a *recognisable reality* (Schatzman and Strauss, 1973) with which others in similar situations could identify.

From the educational point of view, there were two issues about the generalisability of case data in this context. The cases illuminated problems and processes of current multiprofessional working to set alongside the aims and content of shared learning curricula. This added theoretical evidence to help address the question of congruence between multiprofessional practice and preparation through shared learning. The findings were also utilised in considering what kinds of models of shared learning would be appropriate. The literature on teamwork identifies such aspects as roles, focus, communication and conflict as significant; the case studies were likely to illustrate these in action, and possibly show other dimensions from which further theoretical generalisations (Sharp, 1998) could be derived.

Methods of data collection

One member of the research team carried out the fieldwork for the case studies; this facilitated constant comparative analysis across the six sites as well as within single sites, allowing similarities and differences to be identified and compared. Two other members of the research team provided a critical forum for discussion of the findings from each case and conceptualising the nature of variations between sites.

The researcher engaged in non-participant observation, in-depth semi-structured interviews and the collection of documentary evidence. Further details of methods and sampling are discussed in the introduction to each case.

Observation notes were made contemporaneously, except in sensitive meetings. Interviews were audio-taped and fully transcribed. Relevant documents were photocopied, or comprehensive notes were made from them.

Ethics of case study

Case study is faced with a particularly difficult ethical problem concerning the contextually-bounded nature of the research and the issues raised within that context. How to balance obligations towards individuals, and/or teams, with obligations to publish findings was carefully considered.

One way of attempting to overcome difficulties in publishing potentially sensitive information is negotiation with participants; however, this must be achieved without

undermining the impact of the findings. In this research, teams in the case studies were visited on several occasions to discuss the research process and feedback either with the whole team or a senior representative. These meetings aimed to ensure that participants were aware of what the research would entail. Where negotiation was with a senior representative, all team members were given an information sheet for their agreement. The following issues were agreed:

- involvement would be voluntary
- access to sensitive meetings would be negotiated
- confidentiality and anonymity were assured for individuals and teams
- participants would have access to their interview transcripts to agree their inclusion
- negotiation should be possible where participants were worried about certain responses made in interview
- in order to safeguard the confidentiality of individual members, a summary report would be fed back to the team as a whole
- further agreement on this summary would be sought from the team before the findings were incorporated into the wider data set.

This negotiation process continued later in the research, where a case study was selected for complete representation within the final report. The team was given access to an unabridged but anonymised version of the case study for consultation and agreement.

2.4.1.1 Case 1: The diabetes team

The team was situated in a purpose-built diabetes centre in the grounds of a general hospital. It comprised a consultant diabetologist, two diabetes specialist nurses, two dietitians, and two podiatrists. The team provided assessment, monitoring and education for people with diabetes, operating at the boundaries of primary and secondary care. Only the nurses worked permanently in the centre; other members visited for clinic sessions which were frequently multiprofessional. The team also ran clinic sessions in the nearby outpatient department. Weekly meetings were held for all members, in which it was intended that professionals discussed patient care, developments in diabetes care, and had presentations from outside speakers.

Interviews	1	2	Observations			
Staff	14	10	New patient clinic (assessment)	2x2hr	Adolescent clinic	1x2hr
Patients	3		New patient clinic (education)	3x3hr	Special foot clinic	1x2hr
			Yearly review clinic	5x2hr	Team meeting	5x2hr
Total	27		Nurse-run clinic	4x2hr		

Table 2.3: Summary of data collection in Case 1

2.4.1.2 Case 2: The primary health care team

The practice was in a residential area which was once a village, but had been subsumed within the general conurbation along the south coast. The team comprised four GPs, a practice nurse, practice manager, four reception staff, and a counsellor; the GPs employed all other staff in this group. Other team members, employed by two local trusts, included two health visitors (situated in an office within the practice), a midwife and two district nurses. This latter group had offices elsewhere but visited regularly. Professionals ran a variety of clinics, and, in various permutations, attended meetings on site. Sessions held in this practice were generally monoprofessional.

Interviews	1	2	Observations		
Staff	19	14	General observations	10x3hr	12x2hr
			Meetings	4x3hr	5x1.5hr
			Antenatal clinic	2x2hr	
			Practice nurse clinic	2x2hr	
			GP surgery	1x2hr	
Total	33		Child health	2x2hr	

Table 2.4: Summary of data collection in Case 2

2.4.1.3 Case 3: The medical ward team

The team operated in a 26-bed medical ward with a respiratory focus, housed within a multifacility area known as a 'respiratory village'. The ward was divided into six bedded bays, four isolation rooms and a four-bed high dependency unit (HDU); it had 27 qualified and unqualified nursing staff working within a team nursing model.

Because the ward admitted patients who had problems other than acute respiratory, 10 consultants, their registrars, senior housemen (SHO), and housemen (HO) visited. Ward rounds occurred daily, and there was also representation from at least three physiotherapy, and three occupational therapy teams, a variety of specialist nurses, the medical social work (MSW) team, pharmacist, phlebotomist, and cardiology technician. These professionals visited the wards at random times.

Interviews	1	2	Observations		
Nursing staff	10	4	Ward rounds:	consultant-led	x15
Medical staff	5	2		registrar-led	x4
Other professionals	5	1	Ward handovers		x5
			Research strategy meeting		1x2hr
Total	27		General observation		26x3hr

Table 2.5: Summary of data collection in Case 3

2.4.1.4 Case 4: The rehabilitation unit team

This team worked in a purpose-built 20-bed unit located in a residential environment. It catered for medically stable patients who had recently suffered brain damage and were given a tailored course of therapy within a highly-structured, problem-focused, goal-oriented programme. Collaborative note-keeping had been developed to further multiprofessional working and assist the care process. The unit was headed by a non-medical director, with medical cover given by local GPs. The staff comprised a large group of nurses and nursing assistants who operated a team nursing model, with five patients per team. Other professionals included physiotherapists (PTs), occupational therapists (OTs), speech and language therapists (SLTs), a social worker (SW) and a clinical psychologist.

Interviews	21	Observations included	
Heads of department	9x2hr	Case conferences	2x2hr
Team meetings	3x1hr	Rehab. planning	18x2hr
Nursing handover	3x1hr	Problems planning	2x30min
Training	2x3hr	Problem identification	6x30min
Assessment	1x4hr	Cognitive management	1x30min
Joint sessions	4x30min	Report writing	2x1hr

Table 2.6: Summary of data collection in Case 4

2.4.1.5 Case 5: The child development assessment team

Most of this team operated within a purpose-built centre in the grounds of a children's hospital but belonging to a different trust. The team comprised paediatric consultants, SLTs, PTs, OTs, a playroom teacher, nursery nurses, psychologists and a health visitor. Physiotherapists were employed by the trust and only visited the centre as necessary. The team provided assessment, therapy and monitoring mainly for very young children with special needs (some professionals also had responsibility for school-age children).

The work of the team involved a large number of clinic and therapy sessions; all children were seen by appointment except for a drop-in time for children with sensory deprivation. Several therapy sessions and the drop-in session were multiprofessional.

Interviews	1	2		
	19	5	Total	24
Observations included				
Team meetings	7x1hr		Management meetings	1x3hr
Introductory assessment groups	7x2hr		Child development reviews	4x1hr
Language groups	5x2hr		Multidisciplinary reviews	2x1hr
Opportunity groups	6x3hr		Friends of the centre meeting	1x2hr
Eating and drinking meetings	2x1hr		Introductory group case discussions	2x1hr
Planning meetings	6x2hr		Clinics	2x3hr

Table 2.7: Summary of data collection in Case 5

2.4.1.6 Case 6: The community mental health team

Two such teams were included in this case study. They comprised community psychiatric nurses (CPNs), SWs, an OT who worked between the two teams, and one consultant psychiatrist for each team. As such, the teams brought together professionals from both the health and the social services. Clinical psychologists were also members, but worked in a distant location and were only seen briefly at one team meeting during the study.

The teams operated from adjoining offices within a former inpatient facility. Their overall focus, within a specific geographical location, was to manage the care of people aged 18-65 years with severe or enduring mental health problems. The psychiatrists and those social workers who were sufficiently qualified, utilised legislation to place people into inpatient facilities as required. The team liaised with other mental health facilities such as a day hospital, inpatient and outpatient sites.

Much of the teams' business was conducted on a monoprofessional basis, but there was one weekly multiprofessional meeting related to case discussion.

Interviews	**22**		
Observations included			
Team meetings	10x1.5hr & 10x2.5hr	Allocation meetings	3x2hr
Ward rounds	10x4hr	Business meeting	1x2hr
Care Programme Approach reviews	2x1hr	Mental Health Act tribunal	1x2hr
Domestic visits (SW & CPN)	2x3hr		

Table 2.8: Summary of data collection in Case 6

2.4.1.7 Case study in Finland

After the research began, the team heard of an initiative in Finland in which a former tuberculosis hospital had been acquired by a polytechnic to be run as a rehabilitation unit by its institute of nursing, providing a multiprofessional clinical area for the education of students and a service for the local community.

Two preliminary visits suggested that the curriculum model integrated thinking about theory and practice in an approach which the research team had not come across elsewhere. An evaluation of the programme was too large an undertaking; however, Finnish colleagues were interested in investigating the support and training needs of staff to enable them to act as preceptors to multiprofessional groups of students. If a mixed group of students is working with a patient, how does a preceptor from one particular profession use the learning opportunity for the benefit of all students?

The research team suspected that, as shared learning developed in Britain, there would be increasing interest in this question. Preliminary case study work had already indicated that the most effective teamwork involved education by team members across professional boundaries; its development at student level would open up thinking about how knowledge is imparted in teams. Fostering multiprofessional learning in clinical areas as well as in the classroom is an important aspect of multiprofessional education. In some areas of Britain clinical supervision was already provided by members of another profession, but with a same-profession supervisor as a 'backstop'.

The research team was keen to incorporate the Finnish experience in the research, and arranged further visits to collect data; details about the context are given in Chapter 11.

Data collection

Six five-day visits were made: five to collect data over a six-month period, and one to discuss and obtain feedback on findings. The researcher who carried out the British case studies was present on each occasion, accompanied by one other member of the research team including a physiotherapy teacher (once) and an occupational therapy teacher (once). The short periods for observation and interviewing, and potential language problems suggested the value of having two researchers present.

The methods used were interviews with staff and students, observation of meetings, video recording and participant observation of some activities. This latter aspect included recording one multiprofessional supervision session where the physiotherapy teacher taught a nurse, a care assistant and two physiotherapy students about lifting and moving a hemiplegic patient. A video recording was subsequently made of the two physiotherapy students teaching a group of nursing students the same techniques.

Timing and sampling

The research visits were timed to coincide with the presence of nursing students at different stages of their education; a random sample of four students was chosen at each of three visits in order to explore differences in perceptions and behaviours regarding multiprofessional working, dependent on being a first-, second- or third-year student.

The visits were also timed to coincide with the presence of physiotherapy and occupational therapy students, to observe multiprofessional supervision sessions. Since there were few students from these professions, all were observed and interviewed.

In terms of preceptors, clinical nurse and physiotherapy teachers present during the six-month period were interviewed, as were all PTs and the OT involved in preceptorship. Finally, the head nurses of both wards were interviewed.

Most interviews lasted for 30-40 minutes; however, where participants were translating and interpreting the video recording of the multiprofessional supervision session, interviews took up to two hours.

Interviews				Observations	
Nurses	4	Students (N)	10	Ward handovers	2x1hr
Physiotherapists	4	Students (PT)	6	Multiprofessional meetings	2x1hr
OT	1	Students (OT)	2	Eating and drinking group	1x1hr
SLT	1	Students (CT)	3	Activity groups	1x2hr
Nurse teachers	3	(1x2hr)		Multiprofessional supervision	1x2hr
PT teachers	2	(1x2hr)		Lifting and handling supervision	1x2hr
Nurse leaders	2	(1x2hr)		Washing and dressing supervision	1x1hr
Total staff	**17**	**Total students**	**21**		

Table 2.9: Summary of data collection in the Finnish case

Language

Our Finnish colleagues spoke very good English, as did many students and staff. However, it was recognised that there would be problems in interviewing some people. Where possible interviews were conducted alone with the interviewee; however, where necessary they were translated by a peer.

Subsequent translations of observed dialogue were given by the participants. With the video recordings, what began as a means of overcoming language difficulties resulted in the recognition of a potentially powerful tool for multiprofessional teaching and learning (see Chapter 11).

2.4.1.8 Analysis of the case study data

Data were coded and categorised according to topics arising from the interviews. These were then compared and contrasted across the interviews for frequency and inter-relationships. These data were triangulated with illustrations from observation data, and documentary evidence, either to reinforce or offer alternative explanation for the issues under examination (Glaser and Strauss, 1965; Strauss and Corbin, 1990). In this way specific aspects of interprofessional interaction and the influences upon it were focused upon, and a conceptual framework of the main themes associated with multiprofessional teamworking was developed. These related to the organisation, the group, and individual philosophies of teamworking.

2.4.2 Higher education provision for shared learning

The aim was to review and explore the stage reached and direction taken for programmes in shared learning across the country at pre- and post-qualifying levels, with the purpose of documenting what had taken place and what curriculum developments were planned, analysing the driving forces behind different developments, the implications for students and their relationship with clinical needs.

A funnelling system of information gathering was used, starting with a two-part national survey (Oppenheim, 1992; Youngman, 1984), then telephone interviews (Cassiani et al., 1992) with a sample of respondents, followed by visits to a smaller sample.

2.4.2.1 Surveys

Information was sought from all higher education institutions in the UK running or planning initial or continuing programmes of education for health and social care professionals. Copies of a first questionnaire seeking information about the extent of shared learning provision were sent to a named person in each of 181 faculties/departments. The survey was not restricted to institutions offering nursing education: 74 had a total of 206 multiprofessional initiatives running or under development. A second questionnaire, exploring the nature and purpose of shared learning initiatives in greater depth was sent to these respondents, resulting in details of 95 programmes completed and returned.

2.4.2.2 Telephone interviews

The main purpose of the telephone interviews was to follow up a sample of the questionnaires to clarify and explore issues raised by the initial responses. The interviews were rich sources of data because respondents were open in discussing the challenges faced by those involved in the initiatives and the resulting differences between the curricula as planned and as implemented.

Selection of subjects for telephone interview began with a categorisation of the multiprofessional initiatives identified in the questionnaires as follows: pre- and post-qualification; long and short programmes; initiatives initiated by higher education and by service providers; shared learning early and late in the programme; different modes of shared learning; and institutions with a large number of multiprofessional initiatives.

Some initiatives involved both pre- and post-qualification students, and all included nurses. Shared learning which only involved nurses, and programmes leading to qualification in more than one profession were excluded; this left 78 initiatives.

Difficulties in contacting some of those who had completed the questionnaires and the reluctance of a few to give a telephone interview meant that some initiatives could not be pursued. Other factors also affected the follow-up of initiatives in the original categories:

- as initiatives were explored the picture presented in the questionnaire was altered by the respondent's perception and it no longer fitted the category
- issues arose in the interview which suggested alternative initiatives to follow up
- additional initiatives came to light which appeared worthy of follow-up.

By the end of the telephone interview process the research team had:

- carried out interviews in each of the original categories where programmes were available and respondents were willing
- followed up the major issues raised in the early interviews by looking for other examples where the same strategies were used or problems identified
- looked at additional initiatives where they appeared to have something new to contribute.

This process covered 23 initiatives in 21 interviews (Table 2.10). In most cases, the interview was with the programme co-ordinator, who was therefore involved in both planning and implementation. All respondents were assured of confidentiality. Interviews took an average of 35 minutes; they were not taped, but detailed notes were taken and typed up.

Dimension 1			
Initial education	11	initiatives	5 involved modules that could be taken as part of initial or continuing education
Continuing education	17	initiatives	
Dimension 2			
Foundation knowledge	8	initiatives	A number of broad-based programmes covered learning falling into more than one category
Clinical role	16	initiatives	
Broad professional role	8	initiatives	
Dimension 3			
Higher education-instigated	17	initiatives	2 questionnaires no response
NHS-instigated	1	initiative	
HE + NHS	3	initiatives	
Dimension 4			
Workshop etc.	5	initiatives	
Module(s) short course	10	initiatives	
Long programme	8	initiatives	
Dimension 5			
Initiatives involving:			
Nurses	20		
Health visitors	14		
Physiotherapists	12		
Midwives	9		
Occupational therapists	8		
Radiographers	7		
Social workers	7		
Doctors	7		
Speech therapists	4		
Podiatrists	3		
Dietitians	2		
Orthoptists	2		
Nursery nurse	1		
Clinical psychologist	1		
Teacher	1		
Health educator	1		
Prison officer	1		
Pharmacist	1		
Dentist	1		
Dimension 6	1	planned	
	22	planned and implemented	

Table 2.10: The telephone interviews: 21 interviews covering 23 initiatives

Questions asked in each telephone interview were not standardised although they had common elements. This was because a number of questionnaires had information gaps or

responses which were open to more than one interpretation, which meant there was a need to clarify the situation through the interviews. The questionnaires also raised different issues in relation to the nature of the student cohort, expected learning outcome, perceived advantages and problems etc. Although issues raised by a respondent can influence questions asked of others, the focus for each interview had to be individualised.

However, a number of core areas were open to limited exploration within the questionnaire format but which respondents could be asked to expand upon verbally:

- the relationship between health care providers and higher education providers in relation to the initiative
- the rationale for the initiative and expected learning outcomes
- the expected benefit of multiprofessional education and the degree to which it had been realised
- the nature of the teaching/facilitation processes and the response of students
- barriers and enablers in the development of multiprofessional education.

2.4.2.3 Visits to initiatives

A sample of seven programmes was chosen to visit to obtain more detailed information about their planning, organisation and delivery. Each was different in aims and participants and it was not intended to evaluate their success. In selecting the sample, it was found that many programmes were open to a range of professionals but did not actually recruit from that range. The reasons for selection of the sample and the data collected are given below.

- A one-day workshop on advanced clinical skills for final-year medical students and recently-qualified nurses.

  Why selected: Although programmes involving doctors and nurses have a particular importance because of their interaction in the clinical area, the survey identified few examples. This programme also had an explicit intention to facilitate teamworking.

  Data gathered: Observation of the day; interviews with medical and nurse teachers leading the workshop; informal discussion with the seven nurses and six medical students about their perceptions of the day.

- A programme of education for qualified staff, open to a variety of professions and aiming to facilitate the development of clinical effectiveness.

  Why selected: Clinical effectiveness is an important issue in education and practice. The team expected to gain insight into how multiprofessional education would promote multiprofessional working.

  Data gathered: Interviews with three staff managing and/or implementing the programme; discussion with two students (nurse and PT) in relation to the programme and their projects.

- A faculty of health providing shared modules for students in the first year of initial training (study and research skills: the social context of professional health/social care).

  Why selected: An example of initial education involving students from a broad range of professions (radiographers, SWs, OTs, PTs, SLTs, nurses and midwives).

  Data gathered: Interviews with the dean and seven other staff involved with the programme; review of outline documentation; interview with two students.

- An advanced life support course.

  Why selected: An example of a knowledge/skills-based programme involving doctors and nurses with a broad range of experience, which runs in numerous centres

throughout the UK. (The programme was open to paramedics, but none were included on this occasion.)

Data gathered: Review of programme documentation; observation of the two-day programme; interview with the organiser; informal discussions with 12 of the 30 students and four of the 12 teaching staff. Both groups included doctors and nurses.

- A healthy alliances workshop.

  Why selected: This was one of the few initiatives in which teamworking was the explicit focus for the whole event. The case study/role play methodology was also of particular interest.

  Data gathered: Discussion with the manager as follow-up to a detailed telephone interview; interviews with four students at different stages on the programme.

- A combined department of obstetrics, gynaecology and midwifery.

  Why selected: A successful amalgamation of educational provision for two professional groups offering an opportunity to explore the relationships between midwifery and nursing and between midwifery and their medical colleagues.

  Data gathered: Interviews with the lead midwife and two other members of staff, one of whom volunteered a student perspective because she was undertaking a multiprofessional programme run by the department.

- A palliative care workshop for GPs and community nurses.

  Why selected: An example of community-focused education involving these important professional groups.

  Data gathered: A whole-day observation of teaching and learning; interviews with the lead nurse teacher and medical teacher; informal discussion with five of the 20 students.

Staff were open in discussing the challenges they faced as well as the positive aspects of their initiatives. They provided documentary information about the university context as well as the particular initiatives discussed.

2.4.3 Perspectives of trust managers

The aim was to elicit the perspectives of a sample of trust managers and appropriate senior NHS executives about multiprofessional practice. Representation from nursing, medicine, physiotherapy, occupational therapy, dietetics and radiography was sought. Of those invited to take part, only two managers from physiotherapy and 12 from nursing responded, providing a rather uneven picture of the management perspective.

All managers were interviewed face-to-face except one who was interviewed over the telephone. The semi-structured interviews lasted for approximately one hour and were taped and transcribed. Managers were asked to comment on the following areas:

- the external agenda for multiprofessional education
- the trust's perception of the purpose of a multiprofessional approach
- how financial constraints shape the development of a multiprofessional approach
- whether changes were being made to facilitate a multiprofessional approach
- the form and function of multiskilling within the trusts
- the barriers to multiprofessional learning, both external and internal to the organisations.

2.4.4 Views of professional bodies

The aim was to gain an understanding of the views of different professional bodies about the problems and potential for developing multiprofessional education.

Over 40 bodies represent health and social care professions. Representatives of a sample were interviewed, selected from the professions seen most frequently in the clinical case studies. Some bodies approached for an interview preferred to provide documents setting out their position on multiprofessional education:

- Chartered Institute of Physiotherapists: interview
  College of Occupational Therapists: interview
- Dietetics Board: interview
  Clinical Psychology: provided a position paper
- Council for Professions Supplementary to Medicine: the Deputy Registrar (CPSM) provided and discussed explanatory papers relating to the nine professions covered by the Council
- Central Council for the Education and Training of Social Workers (CCETSW): provided papers on joint CCETSW/ENB programmes
- Standing Committee on Post-graduate Medical and Dental Education: provided a consultative document on multiprofessional education
- General Medical Council (GMC): provided several papers.

2.5 Synthesis and presentation of the data

The synthesis of the data was the final element of the research. Data from the clinical teams about the processes involved in multiprofessional working were examined for their implications for education. The results of the higher education surveys, interviews and visits were analysed to give a national picture of shared learning provision. The key implications for learning arising from the case studies were then compared with what was offered in shared learning programmes of education. This comparison was set within the context of the organisational and managerial challenges for multiprofessional working and for programme development derived from interviews with NHS managers and programme leaders.

The last stage of the synthesis was to consider models of education which would meet the needs of pre- and post-qualification students, based on analysis of the contexts of multiprofessional working and existing educational provision. The data from Finland were considered in this context as a new model of learning, based within a clinical area rather than in the classroom.

The presentation of the data in the following chapters aims to illuminate the real-life issues of professionals working together before the information and discussion of the shared learning programmes offered by universities. The intention is to show the issues in the clinical context for which students are being prepared first, so that readers can judge whether the academic preparation for shared learning fits students' likely needs.

Key points

- There were difficulties in managing dual agenda: the directive to seek evidence for clinical effectiveness against the lack of financial and manpower resources.
- There was an emphasis on nursing role development over and above other professional roles.
- Concerns were raised in the context of multiskilling in relation to:
  - professionals where there were anxieties about deskilling
  - lower-grade generic workers, where workload problems were identified.
- In-house training to support multiprofessional initiatives was only partially developed across trusts.
- Some clinical directorates were perceived to have equal representation of professions, others were not.
- All professions had difficulties with multiprofessional working and learning in relation to the medical role in the team.
- There were concerns that professional bodies would resist multiprofessional shared learning.

3.1 Introduction

The following chapters explore the clinical context of multiprofessional working and the educational context of multiprofessional learning. First, however, the scene is set with examples of how some trust managers viewed and responded to multiprofessional issues. Fourteen members of senior management in nine acute and three community trusts in the south of England were interviewed; 12 interviewees were in nursing or patient services directorates, with nursing backgrounds, and two were physiotherapy managers. This limited snapshot allowed the research team to develop a better understanding of the complexities of management, the difficulties of attempting to marry apparently conflicting Government requirements to provide *'better quality care with ever decreasing budgets'*, but most importantly, how they see shared learning fitting into health care practice.

A number of areas seemed important to explore:

- How did the trusts perceive the external drive for multiprofessional working and learning?
- What were their own agendas for action and why had they developed?
- Were the trusts developing new structures and processes to support a multiprofessional approach?
- What were the internal and external barriers to multiprofessional learning which might impinge on the trusts?

The answers to these questions demonstrated the complex and fluid environment in which both managers and 'grass roots' workers find themselves, and how they are seeking to rationalise areas of conflict.

3.2 The agenda for a multiprofessional approach

Most managers felt that there was a dual message from Government in relation to the development of a more fluid multiprofessional approach to service delivery, supported by

multiprofessional learning. There was an understanding that service delivery needed to change in order to provide care based on evidence of clinical effectiveness. This was partly interpreted as the need for a more cohesive but flexible approach, but there was also a strong financial imperative particularly in relation to multiprofessional learning. One manager's commented:

> *'I think one of the main reasons is mainly financial; that it is actually cheaper and more cost effective to train physios, OTs, nurses and radiographers together.'* (Manager 7)

In terms of response to external directives, trusts varied in the degree to which they were taking steps to change service delivery and the learning to support that. Some had already made structural changes to help to overcome these difficulties, and four had introduced wide-ranging changes to practice involving substantial multiprofessional learning. Others were still identifying the problems of fragmentation related to bed management policies, or were too busy wrestling with monoprofessional education to have given much thought to a multiprofessional approach. Still others had pursued innovative approaches such as integrated care pathways (ICPs) then given up because of *'lack of grass roots support'*.

These differences did not seem to relate to whether the trusts were in acute or community care. The geographical location of the sample may have affected these developments, however one manager claimed that her current trust was more innovative than her previous London hospital. Structural or personnel changes within certain trusts may also have created new opportunities for innovation.

There was a clear message from many managers that there was a need to develop more shared programmes, both at pre- and post-qualification level, and more informal learning processes. For several trusts this latter process was in its infancy. However, the need to reshape professional roles as part of the education process was acknowledged. The rationale for this perception was that future professionals would be required to share a wider knowledge base and more common skills. While acknowledging the core of each specialist role, it was seen that there would be far larger areas of overlap, i.e. more integrated working.

There was an ideological and pragmatic basis for this rationale, however. A major shift in emphasis appeared to be developing, with professional roles becoming dictated by patient need, i.e. away from specific professional role territory, to a more *'dynamic responsive multiskilled workforce'*:

> *'What we have done is say "well what is in the best interests of the patient" and we want to look at that holistically.'* (Manager 1)

However, with fewer professionals and greater demands on stretched resources, the trusts would need to explore the concept of greater role fluidity in any case.

Managers acknowledged the fact that the development of strategies to ensure clinical effectiveness, a proactive response from grass roots workers, and shortfalls in finance and manpower, had fuelled the need to find alternatives to traditional professional practice and address the way in which those roles combined. In effect the same dual message was coming from management as appeared to be coming from Government.

3.2.1 The drive for clinical effectiveness

Many managers commented on the drive to provide evidence of clinical effectiveness as well as efficiency. As a method of examining clinical practice, audit had evolved in some trusts into a research and development programme, and a vast array of initiatives had developed to reshape practice, both monoprofessional and multiprofessional. Where multiprofessional initiatives had developed, managers felt that they had led to more *'integrated multiprofessional working'*.

These initiatives included research projects to explore management of specific conditions. In order to ensure the multiprofessional status of the research, some trusts had impelled professionals to write proposals based on a need to meet criteria for multiprofessional input.

> *'We set up a multiprofessional committee, and so people have to put in a proposal and have it approved by a multiprofessional committee, chaired by a consultant, who happens to be an orthopod; they are very keen in this trust. And one of our criteria is that our projects have to contain a number of disciplines ... so for example if an HV puts in a proposal, if she can say "well I have included school nurses" then it is more likely to get some funding.'* (Manager 6)

Several trusts had introduced ICPs related to specific conditions such as colorectal cancer and breast cancer, and acute medical conditions such as asthma and strokes. Again the pathways required professionals to reflect on their input to the care process. In a similar way, the development of guidelines and protocols was forcing them to think about how they related to other members of the multiprofessional team:

> *'There are lights coming on like that all the time as we get those groups together. So I think that is forcing the groups to recognise that they need to get together to begin to do that.'* (Manager 1)

However, the way in which some of these changes to practice were introduced and promoted had a profound impact on their outcome.

3.2.2 Response from the workers

Several managers felt that some impetus for change in terms of clinical effectiveness had arisen from those working *'at the coal face'*. In turn this was as a result of an evolving change in culture. Although other professionals were seen to contribute, it was perceived that nurses were more prepared to question approaches to patient care:

> *'We are getting more people who are doing the PRDN course, so they are already diplomates. All of those groups are very much focused on reflective practice, "why are we doing it this way", questioning. And some of the traditionally trained nurses don't like being asked "why do you do it that way". We still have those types of people, and everywhere has I guess. But increasingly junior staff are asking those questions.'* (Manager 12)

This rise in reflection on practice was perceived to have led to a realisation that there were ways to restructure service delivery, which included professionals taking on wider aspects of care, and negotiating more comprehensively in the various stages of patient progress. In effect professionals were prepared to look beyond their perspective and embrace an integrated multiprofessional approach.

For some managers, the introduction of ICPs was an example of the importance of grass roots support. Three spoke about the lack of initial success in the development of pathways; one commented that these were originally imposed by the clinical audit department; this approach had not been successful:

> *'It didn't use a model that had any chance of succeeding, because it didn't bring people together round the table. It simply went to the different professionals and said "what's your contribution to this pathway, and at what stage do you make your contribution?".'* (Manager 3)

Given what is understood about the change process (Schein, 1985) the subsequent lack of ownership was not surprising. This manager and others recognised the need for professionals to determine where their practice would benefit from a pathway approach:

'What nursing did with its other colleagues like OTs, chiropodists, and pharmacists; we all got together in a room and thrashed it out over a period of about three months, and came out with something we were all prepared to sign up to.' (Manager 3)

It seems likely that the inclusion of all relevant professionals is fundamental to the success of such an initiative; this will be discussed later in this chapter.

3.2.3 The financial and manpower imperative

Resource shortage has been a fact of life in the NHS for years. This was currently perceived as a major driver in terms of thinking about service delivery:

'I suppose when you look at the philosophy that has developed over the last ten years in terms of the quantitative approach to care management, particularly the targets; waiting times; Patient's Charter standards; the drive to look at reduction in the length of stay; very much financial driven agendas. I think for us as a trust I think it is important because we, like every other trust, are going to have to accommodate the waiting list initiative. We are going to have to look very much more explicitly at our services. The financial arrangements are going to continue for quite some time and the year on year cost improvement programmes for efficiency just continue to force us to look at areas in a very different way.' (Manager 3)

However the response to the Government drive for professionals to deliver services effectively, while being efficient by cutting back on expenditure each year, has been complicated by workforce shortages. More than half of the acute care managers commented on the adverse effects of falling nurse recruitment and the high attrition rate of recently qualified nurses. It was also acknowledged that there were similar shortages in the therapy professions.

'If you think about the therapy services, and nursing, our recruitment problem in the country at the moment is quite amazing. Again it is nice that Frank Dobson has put all this money for the recruitment of more doctors and nurses, but where the hell are we going to get them from in the short term?' (Manager 11)

'So I think there has been a shift in the supply side which has cause us to re-examine what are the things the patient needs, and if we are not going to be able to supply more of the same, what are we going to fill the gaps with, and that is causing all of us to look very radically at our roles.' (Manager 1)

Workforce planning is therefore a vital part of the management role, but the shortages had focused the mind of one manager on the need for multiprofessional workforce planning; presently achieved as a monoprofessional exercise. She felt that this situation impeded flexibility and posed a barrier to multiprofessional education:

'... because you are doing this by professional group for existing professional courses, and that seems to be an endless bureaucratic nightmare we go through every year. Because actually we have to train at risk a lot of the time, because we don't know what we are going to be doing in three years time.' (Manager 7)

It was seen that less money and fewer professionals necessitated radical thinking in terms of how to deliver effective services. Some managers were recognising that future health workers might bear little resemblance to current traditional roles; these simply were not proving to be effective for the continuity of care:

'That is because there are professional boundaries that are becoming more and more counter-productive; roles overlap and who does what for the patient has arisen from professional territorial reasons and for historic reasons. It is now becoming detrimental to patient care. And the time has come to stop and ask the patient what they need, and then decide who is going to do it.' (Manager 6)

One manager saw that the potential changes followed the development of roles that had occurred in America, building on research findings from industry:

'What they discovered was that in an awful lot of processes, an awful lot of people handle things, and we could get less people handling them. And they did the same thing, used the same principles, and tracked the number of people who deal with a patient ... It was initially in hospital settings, and I guess it is mainly relevant to that.' (Manager 12)

Financial and manpower resource shortages were placing trusts in a position of having to think about restructuring roles. Although managers spoke about role changes being a response to clinical effectiveness, it seemed that the drive for efficiency was equally powerful. We have alluded to a number of innovatory strategies which have arisen as a result of those drivers. How were roles redefined as a result, in order to provide this greater focus on integrated patient care?

3.3 The nature of role development

In the process of exploring and developing new approaches to care, there have been major changes in terms of role development. In terms of the development of professional roles, these were made with a specific and integrated focus on patient care, such as the specialist nurse roles. There was also much debate about role development which would incorporate the concept of the generic worker. In this case there was the intention to maximise the efficiency of assistant resources across the professions, i.e. it was to be a centralised role; this was interpreted by several managers as multiskilling.

3.3.1 A bias towards nursing role development?

Although several managers alluded to the need for general professional role development, there seemed to be a bias in terms of who was changing. From the interview evidence it seemed that many of the changes in role were specific to nursing. While it is appreciated that most of the managers were nurses, several spoke as heads of directorates which subsumed the therapy professions, or were responsible for wider professional development. Therefore, they should have been able to identify non-nursing initiatives. However, nurses were described as taking on aspects of the medical role as in cannulation, radiography in terms of fracture identification, pharmacy in terms of prescribing certain drugs, and therapy in terms of rehabilitative exercises. Furthermore there had been a big rise in the number of co-ordinating and facilitating roles.

For example, one trust had introduced a specific collaborative practice nurse specialist. This role was introduced to allow the teaching of cannulation to nurses, but had extended to other skills and professions:

'We set these posts up ... to establish the teaching of what I would call advanced practice skills, but they were not, they were the competencies of cannulation initially. Their role is and was to teach nurses at ward level ... But they have certainly begun to teach the medical students, and occasionally the junior housemen catheterisation; not all that often, but they do. But I think that is very important because it is a step forward.'
(Manager 5)

Another trust had introduced a specialist nurse role to help overcome the problem of developing a culture change to support ICPs. This approach has been successful in other parts of the country in promoting a more cohesive approach to the development of pathways rather than that identified by the manager earlier. This seemed to be a very new role however, with the nurse only having been in post for two weeks at the time of the interview.

One trust had also introduced team support sisters to co-ordinate professional input around specific patient care, ensuring that meetings were held to discuss patient progress, and that information was effectively delivered to appropriate team members. This was part of an initiative to help overcome the fragmentation of patients with a particular condition, across several wards. Although some professionals were suspicious of the role initially it was now proving very successful:

> *'But once it had started then the ward managers couldn't do without her because the junior doctors were saying "well we need her for practical things as well". So that means that the team support sister co-ordinates the total package of care for that patient.'* (Manager 7)

Another new role, however, seemed to extend beyond this kind of development to one where a total package of care was provided by one person rather than a multiprofessional team. This raises the issue of an alternative agenda for multiprofessional education than the development of role flexibility around specific patient processes of care.

This new multiskilled role grew out of an area identified by several acute care trust managers, i.e. the efficient through-put of patients. While there is general awareness of the increased turnover of patients in terms of length of hospital stay, more recently there has been detailed examination of other care processes such as treatment in A&E. For example, an A&E patient would probably require assessment and diagnosis by a doctor, investigations by other professionals such as X-ray staff, followed by treatment by nurses and/or doctors before being discharged or admitted. All these processes involve time: for the patient waiting to see each professional, and for the professionals in bringing their individual input together appropriately. One trust had developed a specialist nurse practitioner role which managed many of these processes in relation to minor injuries. This role was therefore providing a total package of care, since the nurse would admit, assess, diagnose, send for investigation, prescribe, treat and discharge, without the doctor's or pharmacist's input. While time would be saved, the development of this role would seem to have implications for the level of knowledge which underpinned these specialist skills.

The amount of role development pursued by professions other than nurses seemed to be small; only a few managers identified such change. For example, one spoke about how the pharmacists' role had developed allowing them to collaborate with nurses in running anticoagulant clinics. To achieve this collaboration, both professions were working within protocols which included assessment and prescription. Another manager spoke about the way in which the radiographers' role had developed to allow them to perform skills such as cannulation.

One of the physiotherapy managers saw the changes in her trust as being *'mainly about the doctors and nurses'*; she saw the therapy groups as rather marginalised. It was acknowledged by some nursing managers that the nursing role had been addressed more fully than other professions, but it was now time to look at the other professions:

> *'I think that we have a very good support structure to develop these [nursing] roles, and now we are looking at extending the framework to include other professional groups.'* (Manager 1)

It does, however, indicate that perhaps because nursing has been seen as the least defined role (e.g. Fokke, 1994), that it might be most likely to adopt change. Currently, it also

indicates that perhaps the rhetoric around pursuing a multiprofessional approach may be more accurately described as the nurse developing a multiprofessional approach.

3.3.2 The creation of the generic worker

In tandem with the development of specialist roles, there was a perception that some roles would need a wider application. Because of the need to maximise role flexibility this would require the multiskilling of some health workers to cross several professional boundaries. There was ambivalence about the term 'multiskilling', however. In several of the interviews its interpretation related mainly to the creation of generic health workers rather than developing the skills of more professionals. The fear was expressed by some that multiskilling was actually about deskilling:

> *'I suppose one should say that it is for the aid of patient care, to provide better patient care; some of the cynics amongst us may look at it as multiskilling, perhaps down-skilling, in order to get cheaper staff.'*
> (Manager 13)

> *'I think if you are doing it [multiprofessional education] for financial reasons you may not be improving individual professions, you could be creating jack of all trades rather then specialist individuals. I have a very close relationship with the head of OT, and we are both adamant that we do not want generic therapists; generic assistants yes, that would be a good thing ... But they would only work to a certain level.'* (Manager 14)

As this last quote suggests, those who responded in this fashion saw multiskilling as a route for non-professionals, interpreting the concept as centralised roles providing a generic workforce. In keeping with this interpretation, several trusts had discussed the development of, or introduced generic low-grade staff:

> *'Some of the support workers are being multiskilled, and they are being employed with that in mind, but we are not actually looking at multiskilling physios, nurses, OTs or anyone like that.'* (Manager 8)

> *'There are aspects of every worker's role, for example, that could be taken up; the more practical aspects of a worker's role, by not necessarily academically trained individuals, but someone who ... can reach certain levels of competence, with internal training and support, to meet a generic need.'* (Manager 9)

> *'... like having a person on the ward ... who will do some of the work that the auxiliaries do, some of the work that the ward clerk does, the domestic does, that can change light bulbs, be a handy person. If we could develop that sort of a role, then that makes sense. But you hear it happening in other trusts where you end up with somebody that you feel isn't quite as skilled in all the bits that they are trying to do. That's not the ideal. If we can do it so that we get the ideal, then it could be better.'*
> (Manager 2)

Some managers identified that these people would be able to assist nurses, PTs, and OTs in the wards and units. They would be multilevel assistants; from those at NVQ Level 1, who would help domestic staff and serve meals, to those at Level 3 who would be more technically skilled, for example taking blood and doing ECGs. The two physiotherapy managers perceived that only those at Level 3 would be able to assist them in 'carry over' techniques.

Where this system had been introduced it had not been perceived as particularly successful because of the lack of resources:

'It didn't work here because what they did was to take the existing staff and make the domestic staff and the NAs into the skill development workers. And they were just rushed off their feet poor things. They were having to serve the meals, they did the dressings, cleaned the toilets, clean the floors. The only thing we learned from it really was that in principle it was a good idea, but that the generic staff had to be in addition to our existing staff.' (Manager 14)

Given the process of role changes spoken about within many of the trusts, what steps were being taken to help professionals to acquire the skills and knowledge to perform their role, or to convey them to others? Also, how were trusts promoting learning for multiprofessional teamwork?

3.4 Trusts' responsiveness to multiprofessional learning

There were differences in how strongly the trusts were promoting multiprofessional learning and whether this was to support multiprofessional initiatives or to create developed nursing roles. However, there was debate about multiprofessional shared learning; it had been raised on the agenda.

It was clear that some trusts had recognised that their clinical research and audit had raised an awareness of the need for professionals to learn together as professionals and from each other. For example it was noted by three managers that the process of working together on various projects, and writing multiprofessional protocols and guidelines, had initiated multiprofessional learning; this was not as a formal procedure but part of the project process:

'Because they are working together more closely in terms of reviewing their roles to meet that need, the commonalities of learning are bubbling up, and beginning to be seen ... for example, we have developed a common policy for expansion of the roles of nursing and professions allied to medicine.' (Manager 7)

Comments from managers showed an acceptance that some skills – both interpersonal and technical – could be learned together or from each other. There was also evidence that learning needed to be formal, that is, the wish for a common foundation for all health professionals:

'A lot of the core elements of training are the same across all the professions; so it is wasteful to teach them in isolation ... Also, as, increasingly, health care focuses on team approaches to delivery of care, it makes sense to get these teams together right at the time that they are learning their jobs if you like.' (Manager 12)

'I genuinely do believe now that what we have to do on a national basis is develop a common foundation programme; I know it is a long way ahead, but we have to be really flexible.' (Manager 5)

'It is about core curricula; it's about looking at how professions are structured in terms of their initial training and education. I think until you've got core modules and opportunities at post-registration level to participate in shared learning, it will continue to be difficult to create it at the sort of level we have done here.' (Manager 3)

How was this awareness translated in terms of the trusts' in-house multiprofessional learning or supportiveness in encouraging attendance on multiprofessional training programmes? It would seem from the interviews that there is little systematic work on shared learning being done in, or on behalf of, any of the trusts. Where ICPs had been developed or research projects

undertaken, there was some specific shared learning; i.e. it had come out of the process of exploring a new approach. Discussions around the writing of guidelines or protocols was seen to have led to a greater understanding of others' contribution to care, and improved multiprofessional teamworking as a result:

> *'We have an acute pain management service which is a partnership arrangement between the nursing and the anaesthetic consultants. We have a specialist pain nurse whose responsibility is to actually educate juniors, whether they be nursing staff or whether they be doctors, or physios or whatever. So there are joint workshops, joint seminars and there's supervision of doctors by nurses and vice versa. And that has worked very well indeed.'* (Manager 3)

As described earlier, one trust had developed the minor injury nurse role. In the early part of this development process the manager acknowledged that learning was one-way, from the radiographer or pharmacist to the nurses. The radiographer would teach the nurses how to identify fractures, and the pharmacist would advise on prescribing. However, later it was identified that radiographers could save other professionals' time if they could cannulate patients prior to X-rays; this procedure was taught by the nurse practitioners. This reciprocal learning process is reminiscent of the case study rehabilitation team's pooling of skills and knowledge, and provided the same perception of continuity of care, particularly since the acquired skills allowed nurses to prescribe out of hours.

As well as teaching technical skills, some practitioners used multiprofessional situations to teach interpersonal skills such as assessment and communication. For example, some trusts had developed common policies on role development. One such trust's manager again commented on the slow dawning of awareness that the learning could be reciprocal:

> *'... the way we developed a common policy was, for instance in prescribing within protocols, both our nurses and our pharmacists prescribed within protocol. Now the nurses need the pharmacological development, the pharmacists, although they didn't recognise it to begin with, needed the assessment skills. I said "well OK, I'm a patient in bed with a pain in my leg, what would you do?" And the pharmacist immediately said "well I would look at what drugs they were on and I would think about paracetamol etc. etc." He hadn't thought to look at the leg, and that brought it home very graphically to them that they needed skills in actually assessing the patient.'* (Manager 7)

A second example of skills teaching was where there had been co-ordinating or facilitating roles such as the team support sister. This role also provided opportunities for greater discussion with medical staff, and led to some teaching sessions with the ward nurses and junior doctors:

> *'One of ours [specialist nurse practitioners] is an ex ITU nurse, and she is very good at giving bad news, and she has made that a real hobby horse of hers, that every new doctor assigned to that team is helped by her, especially the very new ones in terms of breaking bad news.'* (Manager 7)

In order to promote better understanding of how professionals could work together and what that would mean for their roles, one trust had introduced preparatory change management training:

> *'There's lots of impact analysis so that people choose projects that are relevant, and all that training is always multiprofessional. We invite Health Quality Quest, very expensive, to come in and run training days ... it is such a good day that word gets around. So the first one there was stick, carrot anything you like, in order to get people on to this course, and*

they got a cracking good lunch etc. Then they spend the afternoon working up a real proposal that they present. And they do that in teams, they have to work in teams.' (Manager 6)

A final aspect of in-house shared learning was the development of team training in terms of exploring common processes of service delivery. This was only spoken about by managers in community trusts, particularly with regard to assisting the community mental health teams to grasp new concepts such as the Care Programme Approach (CPA). Only one manager spoke about this approach as a whole team process; others spoke about CPNs and SWs being involved with their managers. (However, a national primary health care team training programme has for the past few years been run by multiprofessional 'local ownership teams'. This has been available in this region and has trained a number of general practice teams.)

Where post-qualification programmes were available, several managers commented that they encouraged staff from across the professions to attend; those mentioned were MScs on communication and IT, and management programmes. However, some managers mentioned that only certain professions applied for certain programmes, so that while a multiprofessional input was hoped for, it rarely happened. For example, counselling programmes were open to all professions but were mainly taken up by OTs in one trust, in order that they could instigate group-work. Some managers recognised the need to promote the multiprofessional appeal of some programmes to more professionals, but were aware of the inhibiting effect of some professional management:

'... maybe they are not moving with the times as much as we would wish. It is not all of them by any means, but we do have some people, and the problem is that they have influence on their PAMs and scientist colleagues as well to maintain the status quo ... I think [that is] part of the reason why, although courses are open to all professions, they tend not to be nominated.' (Manager 12)

In order to support the development of multiprofessional shared learning, managers acknowledged that they have needed to become creative in acquiring funding. For example, some spoke about using traditionally monoprofessional funding and person days, in a multiprofessional fashion. (This only applied to nurses and PAMs however, since medical training had its own *'vast amounts of money'* from the Council for Medical Education.)

Since several of the managers interviewed also sat on local education consortia, there was widespread recognition of these bodies' role in promoting multiprofessional shared learning, particularly since many had acquired devolved budgets. The consortia seemed to facilitate the development of a wider perspective for trust managers, allowing them to see more clearly the links between what is learned and what culture develops in the workplace. Several of these managers recognised the need for congruence in terms of pre- and post-qualification education, in-house learning, and organisational structure and process.

3.5 The development of supportive multiprofessional structures and processes

Given the awareness of the need for the organisation to support a multiprofessional approach to working and learning, how did the managers see that their own trusts had developed appropriate structures and processes? It could be supposed that if multiprofessional working was to be enhanced by multiprofessional learning, organisations would be promoting a more coherent multiprofessional working environment.

3.5.1 Separate professional management

Many managers commented that separate management could pose problems for the development of multiprofessional teamworking. However some saw that the directorate system

(within which all managers operated) provided a route for multiprofessional team development, since it was multiprofessional management at all levels:

> *'We have a director of clinical services who manages all of the clinical services. But in order to make that strategic reality, what we have is a sub-committee of the trust board which is the Professional Practice Committee, and that committee has representatives of all the professions, including the clinical director and also the clinical tutor. So I think that is a critical arm which actually gets the multiprofessional thing working well.'* (Manager 4)

> *'The staff within the directorates are managed by the clinical director, who is a doctor. And now we have all the other professions within a directorate too. The physios for example are managed within the orthopaedic directorate; they are managed by a consultant surgeon.'* (Manager 2)

Although there was generally a multiprofessional executive board comprising clinical directors and other chiefs of services directorates, not all managers were health professionals, not all professional strands were represented, and where they were there was a perception that not all had an equal voice. Any or all of these situation could have undermined the development of multiprofessional practice since they raised issues around appropriateness and balance in decision-making. One nursing director commented:

> *'We have a directorate of nursing, and the reason for that was that nursing was beginning to get lost out in the directorates. It wasn't particularly strong, and there had been a lot of rationalising of senior posts, and it had lost its way really. The general management structure ... didn't include nurses, so that decisions about nurses were being made by non-nurses.'* (Manager 3)

And one physiotherapy manager made the following comment:

> *'We are very much against having communication through the nursing directorate. Basically it is because we get forgotten. It has always been assumed through the NHS and region that everything has come down to the PAMs through the nursing and quality directorates, and we never get the information, or if we do get it, it is past any closing dates, and we have suffered a lot in the past because of that. Which is why we have fought not to be lumped in the nursing and quality directorate.'* (Manager 13)

The issue of non-health professional management had to a large extent been dealt with in terms of clinical and practice directorates. With a history of perceived adverse decision-making, these structures had been realigned. In terms of the lack of representation and perceptions of inequality, both these situations resulted in difficulties in expressing the wishes and concerns of the individual professions:

> *'I am still sorting out now decisions that were made in midwifery five years ago, when they [general managers] gave up a number of posts as part of a cost improvement programme.'* (Manager 3)

Therefore, despite a mechanism for negotiation, this was not always done on the basis of a comprehensive set of perspectives. For example, in some trusts small specific clinical directorates included the managers of many of the professionals that would serve the particular patient group. The orthopaedic directorate was mentioned by two trusts as providing this type of structure since it included medical, nursing, physiotherapy and occupational therapy management. At first glance this would seem to provide the opportunity for practice development, since all relevant managers would form part of a multiprofessional board which reported to the

clinical director. However, it could also reinforce traditional hierarchies, since most of the clinical directors were consultants. This was traditional hierarchical teamwork writ large.

In some trusts, the perception that nursing did not have a sufficiently loud voice in directing and developing practice strategies resulted in their forming separate nursing practice directorates. This was perceived as providing a more powerful voice, but separated them from the clinical specialty (where they also still had representation, but not specifically related to practice development). Where there was this separate nursing configuration, in two instances the therapy professions were subsumed within the nursing directorate. As indicated by the second quote cited above, this was also perceived to promote difficulties with the therapy professions. Where this was experienced, clinical services directorates had been formed containing only therapists and other PAMs, such as pharmacy. The emerging picture was of constant change as difficulties arose and were accommodated; indeed several trusts were still undergoing changes at the time of the interviews.

On the question of whether trusts had overcome the problems of monoprofessional management, therefore, the answer seems to be equivocal. There was a system which could have promoted the development of cohesive multiprofessional working. Where there were smaller focused groups of professionals, for example, around a specialty such as orthopaedics, joint decision making at management level would be possible. However, the extent to which the various professions would feel that they had been able to put their case adequately would depend on the flexibility of the clinical director, usually a consultant. As will be seen later, consultants in many trusts were perceived to have caused dislocation in the path to multiprofessional working and learning.

> *'I think that is the disadvantage. I think the clinical director role is really important in terms of leadership, but then I am then uncomfortable because the model here is medical. The forums that exist as part of the structure include things like the clinical board which is multiprofessional; there's myself, and there's PAMs, and the pharmacist or whatever, chaired by the medical director, and one is constantly having to fight to make sure that ... things are looked at from a multiprofessional perspective. Yet the theory is that it should work, it should take care of that. But it doesn't quite yet.'* (Manager 3)

One manager spoke about an alternative to the problem of equal representation. His trust had developed a multiprofessional practice board, which was seen as useful for taking on issues from grass roots workers if they could not be heard within their own directorate. This structure was identified by two other managers as being helpful in terms of listening to those attempting to operate in a multiprofessional fashion.

3.5.2 Fragmentation

A second difficulty in maintaining multiprofessional working in the acute sector was the fragmentation created by bed filling policies. Many trusts had been wrestling with this problem, as shown by this typical quote:

> *'I'm very aware of what that fragmentation did, and how destructive it was. Certainly in my earlier role as a general manager for elderly care for about a year and a half, I saw how difficult things were getting; we had patients all over the medical wards, surgical wards, you name it.'* (Manager 5)

Radical steps had been taken by some of the acute trusts, including the instigation of acute medical admissions wards with a stable nursing and medical team. Here, patients were admitted briefly in order to assess and make preliminary investigations, and subsequently sent to the appropriate wards. Although the therapy professionals still operated on a wider basis than this, they were allocated to specific wards. This was seen as a move back towards the more stable

traditional environment. In one manager's words it was perceived that *'the team is back, and it [the reorganisation] has helped a lot'* (Manager 5):

In two of the trusts that had made these changes, one was proposing to develop integrated note-keeping, and one had introduced collective note-keeping. Unlike an integrated system, this was a mobile box in which patients' folders were kept, each containing separate notes made by relevant professionals. The physiotherapy manager in this trust commented:

> *'It does work though and it is lovely because for example we can't be at case conferences and ward rounds on every ward that our consultant goes to, so it is much easier for him to pull the notes in one fell swoop, so that he can look at the doctors' notes, and the nursing and therapy notes as well.'* (Manager 14)

In order to provide a form of shorthand of changes made by the various professionals, this collective notes system was underpinned by the introduction of white boards above every patient's bed. On these, the professionals could note specific changes to their care, or patients' progress:

> *'If they want to read through the notes, then it may take a bit of time, so if a patient has maybe changed a walking aid or something like that, we just write that on the multidisciplinary board and say "now walking with two sticks".'* (Manager 14)

Helpful as these attempts to overcome difficulties in multiprofessional working seem to be, such innovations were patchy. Financial barriers may exist within some trusts, inhibiting them from pursuing this type of course. On the other hand, such structural changes may have been perceived as having negative consequences, thus making other trusts cautious. However, the evidence pointed to some organisations having acknowledged the problems for those working in the wards, and had addressed them dynamically, in keeping with their promoting a multiprofessional working ethos.

This chapter has examined several trust managers' understanding of the drivers for multiprofessional shared learning, how that was being developed in their trust, and the supportive structures in the trust for subsequent multiprofessional working. However, there were attitudinal barriers to this pattern of learning and working, chiefly related to perceptions of professional superiority or professional protectiveness. This final section looks at managers' perceptions of the stumbling blocks to providing a coherent multiprofessional approach.

3.6 Perceived barriers to multiprofessional shared learning and working

Despite an awareness that multiprofessional education was likely to be a prominent feature of the health service, both pre- and post-qualification education and in-house training, managers identified barriers to its achievement, and to the working it might inspire. This perception related mainly to resistance from particular professional groups. Although one or two managers identified that some professionals, particularly medical staff, used lack of time as a reason for not attending in-house initiatives, it seems likely that this was used to shield a lack of willingness.

3.6.1 The battle between the sciences and humanities

Some managers were aware that there was still a difference in perception between health work as a science and as an art, and hence a split between doctors and other professionals, and to some degree between pharmacists and other professionals in terms of how skills and knowledge were learned and what was deemed important to learn. One manager, speaking about his concern that the pharmacy department was being moved from the health faculty in a nearby university, to a more specifically science-based faculty said:

'They have just moved from a three- to a four-year training; they perceive themselves as scientists and not health care workers, and that attitude change, you begin to hear messages saying "actually our training is much longer than yours; it has to be because we know so much more than you and our role is different ... We're not health care workers" ... I don't think I'm criticising pharmacists in that because they are scientists, but I just think it is a pity.' (Manager 12)

This division was also perceived by several managers in terms of the medical profession's view that their training needed to be separate:

'Partly I think because they feel they don't need to attend; they already know. Partly because they perceive that they are not going to get anything out of it; they are not going to get any credits, they are not going to get a free lunch; they are not going to get anything out of it for themselves, so therefore they don't see the need to attend.' (Manager 8)

'People like me have got all excited and talked about multiprofessional education and this has really gone down like a lead balloon with the consultants. There is very much this elitist thing, there's a big culture thing. There's no doubt but that the culture of medical training is just so different ... I don't know that they would necessarily articulate this, but this repulsion that they feel about joint education is very much tied to the strange adversarial upbringing you have when you are a medical student.' (Manager 6)

The attitude of the medical profession towards shared learning proved frustrating to some of the managers. It was noted that where there were mechanisms for multiprofessional educational development, as in the sessions held around the development of ICPs, medical staff were frequently absent. This, not surprisingly, gave rise to negative perceptions of the potential success of a particular strategy:

'We have used a stroke pathway throughout the winter emergencies initiative to head up, or provide the framework for the stroke team. So we've got evidence locally that it can work. But getting the medical staff on board has been difficult. It is frustrating and I have tried every which way in.' (Manager 3)

'I was only talking today about the organisation tackling the medical staff on the basis of a strategic development, and all you need is one medic to say "I'm not playing ball", and the whole thing folds. But they get away with it time and time again.' (Manager 11)

Where ICP introduction had failed, the lack of ownership at grass roots was perceived to have been fed by the fact that doctors not only did not take part in the development of the pathway, but would not contribute when it was in operation; they 'opted out' leaving others, nurses in many cases, to bear the brunt of the work.

Furthermore, not only were some doctors unprepared to take part in learning experiences (other than as teachers), but they were also perceived to be unwilling to learn from researched practice. This seemed clearly articulated by the response to some research projects run by nurses. One manager spoke about the difficulties encountered when evidence of best practice had been identified. This was seen by some doctors as inadmissible on the grounds that it had neither resulted from randomised controlled trials (RCTs), nor been conducted by medical staff:

'One consultant was saying that if no doctors are involved then it is not valid, he actually put this in a letter of complaint to our director of

nursing, that as far as he was concerned he wouldn't acknowledge this resource, and that he would still go on using [that particular lotion] in A&E. It is so arrogant, but they haven't the self-awareness to see that it is arrogance.' (Manager 10)

While a RCT may well have been an appropriate research method, the consultant's attitude was extremely unhelpful in facilitating closer multiprofessional working. In addition, the insistence that medical representation would be required as part of the research team underlines the negative perceptions of nursing research held by some members of the medical profession. That nurses would be capable of conducting rigorous and relevant (but not necessarily RCT) research did not seem to occur to this consultant, and reinforces the divide between science-based medical knowledge and humanities-based nursing knowledge. Furthermore, for nurses to collude with this stance would be to undermine the development of evidence-based nursing practice predicated on methods more suitable to discovering how process impacts on outcomes; clinical research concerned with the improvement of care for specific groups of patients within specific settings (Rolfe, 1998). The possibility that some members of the medical profession would be prepared to learn from such research and thus from professionals who use such a research paradigm, would seem to be remote. However, they have a fundamental role in the development of multiprofessional practice; how could this tension be resolved?

Some managers have become opportunistic in seeking out 'on message' consultants and using them to promote multiprofessional approaches. They have also had to seize chance events and promote them. For example, one manager described a situation where her team support practitioner had developed sessions on interpersonal skills such as breaking bad news. This had initially been poorly attended by medical staff. One manager believed that this was because it was a 'soft skill', not seen as vital to the learning needs of junior doctors. This changed when one consultant heard a patient describing his recent care in the hospital; he said that he had found it extremely good, except for the way in which the consultant had told him his diagnosis. Since the consultant had prided himself in this area, it came as a shock to find himself singled out in this fashion. This doctor subsequently became an advocate for the sessions, encouraging his junior doctors to attend, and this fact was used by the nurse to encourage other consultants; that is, she used power credibility to underpin her teaching.

3.6.2 Role flexibility in the therapy professions

In contrast with their experiences with some doctors, many of the managers commented on the willingness of the PAMs to co-operate with nurses on the development of multiprofessional working. However, while some identified that members of the therapy professions, in particular PTs, were enthusiastic about sharing their knowledge and learning about other rationales for practice, this learning did not actually extend to widening the scope of their practice. Unlike the nurses, the PAMs group were not perceived to be as role-flexible:

'I often hear that our therapy service has found it very, very hard to even consider the concept of NVQ training for unqualified physios and OT, etc. Now they found it very difficult to go down that road, but they also found it difficult when nursing staff even contemplate getting involved in some area which they think is their specialism.' (Manager 11)

Furthermore, in the development of one specific ICP it had been identified that it could be useful for PTs to learn about injecting into joints to relieve pain. Working within a protocol the rheumatology nurse practitioner had already taken on this skill. However, the PTs appeared less willing to develop their role:

'Physios could do this kind of thing within a protocol if they wanted to, but they are a bit slow on picking it up. They don't seem to want to pick up the role as much as the others.' (Manager 7)

This manager felt that the PTs did not want to take on anything that was not immediately related to physical movement. This was corroborated by another manager who had noticed the same reticence among members of the therapy professions in participating in strategy discussions; that is, to take on a management role:

> *'I think they are happy to challenge when it's around a clinical issue, but I think that when they are expected to look at developing ... when they are looking at strategic issues like moving towards multiprofessional education, they seem to lack the confidence, and perhaps the knowledge.'*
> (Manager 3)

Other managers identified the opposite problem, where PAMs were unwilling to allow other professionals to take on a perceived part of their role. One manager commented that some nurses in his trust had wanted to introduce relaxation massage as part of their nursing care, but this was felt to be inappropriate by the PTs and construed as 'poaching' their territory. The details of this situation were not known by the manager but may well betray a lack of negotiation on the part of the nursing and physiotherapy management, or indeed those at the 'coal face' of service delivery. The protection of role boundaries has been cited in several pieces of research (e.g. Abramson, 1990; Iles and Auluck, 1990; Øvretveit, 1990; McGrath, 1991; Pearson and Spencer, 1995) and could be linked to situations where discussion of potential changes in role boundaries was not encouraged. The development of shared learning relating to specific role tensions could help to solve this problem.

From the evidence of the two physiotherapy managers, while there was a recognition that greater flexibility of role boundaries was essential in terms of providing continuity, this related largely to nurses and HCAs developing aspects of therapy skills in order to provide weekend and evening 'carry over'. In terms of their participation in shared learning one was not too sure how appropriate this would be with professions other than OT. One manager said:

> *'Well I have difficulty thinking of what areas; what depth of learning could be approached by shared learning. Just an information-giving session could perhaps be shared learning.'* (Manager 13)

However this manager did comment on the development of the physiotherapy role in incontinence care, where PTs were performing internal examinations on women suffering from stress incontinence. This might have indicated a degree of collaborative role development, however it appeared to have been decided unilaterally:

> *'I don't think she [the nurse specialist in incontinence] was particularly included in the discussions in that respect.'* (Manager 13)

As suggested earlier, there was greater evidence of role development in the nursing profession than any other. Consequently the direction of learning has in general been less reciprocal than one would suppose from the rhetoric. The assumption that all professionals could learn from each other (as well as learning a common topic together) does not seem to be widely borne out. Several managers felt that the professional bodies which oversee the path of practice and education may perpetuate that position.

3.6.3 The position of the professional bodies

Several of the managers sat on the education consortia developed nationally. They had particular concerns about the way in which professional bodies would protect their own specific bodies of knowledge. With all the debate about the need for greater role fluidity, with one possible end point being the creation of more generic working, it was felt that the professional bodies would *'pull up the drawbridge'* around their role and the subsequent knowledge and skills required for that role:

'In its widest context they will talk about how valuable it is, provided that it doesn't impinge too much on their separate status. The danger of course is that people end up talking about it and never doing it. And ... some professional bodies' vested interests in the status quo will mean that we have a fight on our hands.' (Manager 12)

It is hard to know how widespread these views were. Among the managers interviewed, only those who had begun to think about developing multiprofessional learning, and who had an active role in the education consortia expressed concern. If the general concept of multiprofessional learning is accepted but interpretations of role fluidity are widely different across the professions, then while common core modules may be developed, there may still be little change at the point of service delivery; the artificial barrier described by some managers would remain.

The personnel on education consortia would seem to be important in this sense. For example, is there representation from across the professions? Where training schools for specific professions do not exist locally, this would seem unlikely. However, a consortium which comprised solely nursing representatives, even where they would expect to be speaking for their PAMs colleagues, would seem to make a nonsense of developing a multiprofessional approach to education.

3.7 Conclusions

What conclusions can be drawn from these examples of a managerial perspective? First, it would seem that there is a greater emphasis on multiskilling a number of professionals, developing their roles in specific or generic ways, rather than developing multiprofessional teamworking. By this we mean there was no reference to in-house multiprofessional learning about teamworking, how professionals could develop more effective communication or better understand each other's role, and how they should develop team strategies. Where ICPs had been developed for instance there was no reference to learning about the process of managing the ICP, only to its initial development by the heads of the professional groups, or the learning of specific skills between the relevant professionals.

Second, although this investigation is limited, this role development seemed to be largely a nursing initiative. What does this mean in terms of multiprofessional teamwork? As suggested earlier are we looking more at the creation of widely role-flexible nurses with specialist input from other professionals when necessary, rather than the promotion of a multiprofessional team in which nurses has their specific nursing contributions to make?

Third, some members of the NHS seem to want to hold themselves aloof from the drive to provide greater role fluidity, and the learning needed to support it. The insular attitude of many in the medical profession was identified in managers' comments as a fundamental inhibitor of multiprofessional working. How to soften the perceptions of the medical profession towards the idea of learning together and demonstrate that it can have a value for them, seems to be important for future 'teamwork'. Similarly, thought would need to be given to those professionals who, though willing to learn with and from others, did not seem convinced that their role development was useful for effective care delivery.

Key points

- The team operated within a highly structured, problem-focused, goal-oriented approach to patient care.
- Multiprofessional practices, such as note-keeping, assessment, monitoring and evaluation were established.
- The practices relied on team members' willingness to be role flexible.
- Being a team player was considered an equally important attribute for staff.
- A learning culture existed and was facilitated and supported by the director and heads of departments.
- Role clarity and confidence were not experienced by all the nurses.
- Although teaching between professionals was common, nurses were not perceived to participate in this role.
- Problem-solving skills in the team varied, possibly related to differences in the use of models of professional knowledge between nursing and PAMs.
- Difficulties were encountered in integrating a newcomer to the team because of a mismatch of philosophies of teamworking.

4.1 Introduction

This chapter is the first of four in which the findings from the six case studies of clinical teams are discussed, and a detailed study of one team is presented. All members of the team were consulted about the publication of the case study and gave their agreement. This case was chosen because it illustrates key aspects of integrated teamwork, and sets the scene for further analysis of issues about collaborative working and the implications for learning, discussed in Chapter 5. Chapters 6 and 7 describe examples from the other case studies showing more fragmented modes of teamwork.

4.2 Participants

The following staff members were interviewed:

- the director
- four occupational therapists (of four)
- five physiotherapists (of six)
- three speech and language therapists (of four)
- four nurses (of 20, but see below)
- one clinical psychologist (of one)
- one social worker (of one)
- the unit administrator (of one)
- one general practitioner (of four, but see below).

Less formal conversations taken from field notes (not including interviewees):

- one physiotherapist
- 10 nurses
- two GPs.

The case study was based in a rehabilitation unit, with one observation session being made during the pre-admission assessment of a patient at an out-of-county hospital. All meetings related to patient process and team management were observed on multiple occasions. Case conferences and joint therapy sessions relating to two patients were also observed. In addition there was document analysis of the collaborative notes, handover books, and nursing notes. All interviewees were interviewed at least once, with the initial interviews lasting 40-50 minutes. Follow-up interviews were carried out where necessary to clarify certain points. All interviewees received a copy of their interview transcript, allowing them to correct misheard or misunderstood information, and to give their agreement to its inclusion in the analysis.

Interviews	**21**		
General observations	39x5hr	including the following meetings:	
Heads of dept	9x2hr	Case conferences	2x2hr
Team meetings	3x1hr	Rehab. planning	18x2hr
Nursing handover	3x1hr	Problem planning	2x30min
Training	2x3hr plus	Problem identification	6x30min
Assessment	1x4hr	Cognitive management	1x30min
Joint sessions	4x30min	Report writing	2x1hr

Table 4.1: Summary statistics of the data collection

In addition to the sessions identified in Table 4.1, a presentation on the collaborative note-keeping system (two hours) was observed. This was given by the director and all heads of departments, to members from other rehabilitation units. Finally, on most days when observing the unit, the researcher was present during the lunch period, when all therapists, some nurses and the director (on occasion), met in the staff room.

4.3 The context

4.3.1 Rehabilitation unit structure

The unit opened as a respite facility in 1988. It was situated at one end of a residential estate on the outskirts of a small town, half a mile from one of the trust hospitals. Although functional, it was tastefully decorated, and looked more homely than a hospital. The unit could house up to 20 patients, who had their own rooms which opened both into the corridor and into a courtyard, where many patients spent their spare time during warm weather. Rooms were equipped with patients' belongings, and each had access to a toilet and shower which was shared with one other room. Also on this side of the building there was the dining area, where patients ate and socialised.

On the other wing of the building, a large open therapy area contained exercise equipment; there were several other therapy-based rooms including a kitchen where OTs supervised patients in domestic activities, and a workshop where patients made objects which exercised cognitive and physical skills. Several small therapy rooms could be used for one-to-one work. Finally this floor housed the main nurse's office and the director's office.

The basement was accessed through a code-protected door in the gym. At the top of the staircase patients' collaborative notes were kept in another code-protected room where staff could spend time writing in these and making other reports. Downstairs there was the staff common area and kitchen, a meeting room, and various offices.

4.3.2 Historical perspective of the unit

Unlike many rehabilitation units, this had no all-embracing medical input. This had not always been the case; the unit was opened under the guidance of a consultant rheumatologist and more closely aligned to a medical model of care. When the consultant moved on, a new position of director was created and was filled for four years by a PT. It was perceived that her time in post determined the strength of the unit's therapeutic culture. Medical cover was now supplied by local GPs.

The current director took over from the PT, having been the unit's full-time social worker for two years. His SW post was replaced by a substantial part-time post, which, a year ago, was reduced to a few hours a week.

Just prior to the study, a part-time clinical psychologist had been appointed. The part-time basis of these two latter roles limited the psychosocial aspect of patients' rehabilitation to some extent.

Many staff had been employed in the unit for some years, indeed one or two nurses had been there almost since its inception. This created a stable core of experienced and knowledgeable professionals for newer members to draw upon for advice and guidance.

4.3.3 The remit of the unit

The unit was contracted to two health authorities, to provide short- to medium-term, goal-oriented rehabilitation programmes to patients who had suffered strokes, traumatic injury, multiple sclerosis, and other cerebral conditions. However, up to 75% of patients at any time could be from outside the area. Prior to admission, usually via referral from the relevant consultant, patients were assessed in their original hospital. Criteria for entry were that:

- the patient's hospital agreed to take them back after the programme had finished
- on assessment the patient was deemed to be 'rehabilitable'
- the patient was clear from methicillin-resistant *Staphylococcus aureus* (a highly drug-resistant bacterium)
- the patient was medically stable.

4.3.4 Unit staff structure

The unit staff consisted of 12 daytime nurses and a number of nursing assistants (NAs), four OTs, five PTs, four SLTs, the director (non-clinical), a part-time SW and clinical psychologist, ancillary staff, and three administrative staff. Medical cover was provided by a local practice of four GPs, all of whom attended the unit for one hour each day, by rotation. The staff were predominantly female except for the director, the clinical psychologist and one primary nurse.

The nurses operated a 24-hour cover shift-system, supervised by a G grade head nurse, under whom were four daytime E grade primary nurses, four D grade associate nurses, and eight NAs. The permanent night staff, worked on day duty for one week in seven in order to retain links with the rest of the team.

The nurses were divided into four groups, each with a primary nurse and associate nurse. These nurses operated on alternate shifts within two Teams, which also included therapists from the other disciplines. These Teams were allotted certain patients, for whom they retained responsibility from admission to discharge (note: the term 'Team' only applies in the chapter to the specific multiprofessional division described above, all other references to team have a small 't').

The therapy disciplines worked Monday to Friday, 8.30am to 4.30pm, during which time they each had a programme of sessions with their patients. Each discipline had a Senior 1

as head of department, but unlike the head of nursing, they carried clinical caseloads. The other members were lower-grade clinicians (Senior 2s and basic grades). Basic grade therapists were on six-monthly rotation and unlikely to return to the unit, and some Senior 2s were on a two-yearly successive rotation where they spent nine months at the parent hospital and the remainder of the time at the unit.

4.3.5 The contribution of staff to the rehabilitation process

4.3.5.1 The director

The director's role was diverse; it was his responsibility to manage the unit's financial and major administrative tasks (with administrative and secretarial support), and to act as the public relations person in the 'outside world'. He dealt also with many initial patient assessments, deciding who would be appropriate for admission, and made final decisions on discharge (with input from clinicians). As the unit was part of the local health care trust, the director also liaised closely with trust management. He described himself as *'head of a federal state, in which all the states have a high degree of autonomy'*. The 'states' comprised the following:

4.3.5.2 The nurses

While their role was debated, the nurses' main responsibilities were to assess and carry out the requisites of patient care. These included the maintenance of continence, skin integrity, and feeding, and administering medication or other medical treatments as prescribed. Another aspect of their work was to 'carry over' prescribed therapeutic interventions. Finally, the nurses acted as the chief line of communication between patients' relatives and medical or therapy staff.

4.3.5.3 The physiotherapists

The PTs worked with most patients, in order to assess and improve their mobility. There were two facets to this improvement: that patients could function as well as possible, and that they could do so with the optimum quality of movement. The emphasis of PTs' input was *physical* treatment.

4.3.5.4 The occupational therapists

The OTs' role was to assess and attend to all areas of *function*. This translated into working with patients to optimise their abilities to manage personal care such as washing and dressing, and to provide modifications which would compensate for any impairments, such as bath seats. They also addressed the activities of daily living, which entailed the provision of mechanised assistance such as wheelchairs, Rolators and other aids. A major aspect of their role was the assessment of aspects of cognition such as memory, perception, and attention, to instigate strategies to help patients overcome their brain trauma, and achieve as much independence as possible.

4.3.5.5 The speech and language therapists

One of the main concerns of the SLTs was the assessment of swallowing, and the provision of programmes to ensure patient safety in this area. They also assessed and worked with communication difficulties, which could be caused by facial paralysis or cognitive impairment. This latter area required them to perform cognitive assessments, but only relating to language.

4.3.5.6 The clinical psychologist

This was a new role, and clearly defined areas of responsibility had not yet been decided. However, it was perceived by most that this role should perform all in-depth

psychological assessments, and advise therapists and nurses of possible programmes of therapy or care.

4.3.5.7 The social worker

Originally this role was to liaise between the unit and support services required when patients were discharged. The SW also advised patients and relatives about benefits and other payments and offered them counselling related to the life trauma they had suffered. As a result of the reduction of her hours, the SW was currently unable to provide any counselling, and her input to the discharge process was reduced to a minimum. The OTs to some extent filled this latter role.

4.3.5.8 Medical cover

The GPs had previously had a greater and more consistent input into the unit. Currently they operated mainly an advisory service, answering queries, being on call for emergencies, prescribing drugs, and authorising investigations. The chief partner had been attempting to formalise the service by instigating a weekly meeting with the nurses in order to discuss all patients, however this had not yet been established with any consistency and structure.

4.4 The communication system

The unit had a highly-structured system of assessment, meetings and written information. While most of this related to the process of patient care, some meetings focused on more general information sharing and Team management.

4.4.1 The process of patient care

4.4.1.1 Assessment

Patients were initially assessed by the unit director while in their original place of care. If a patient's condition was particularly complex, this was performed instead by a team of appropriate professionals from the unit. Within 48 hours of admission to the unit, patients underwent a thorough assessment by each professional group. This included a baseline scoring on two outcome scales; the FIMFAM, an American system addressing mainly functional aspects of cognitive and physical skills; and the Health Assessment Scale (developed by the unit), which took a more qualitative approach to the same skills. Regular monitoring was performed by all disciplines throughout the patient's stay, and prior to discharge. A video recording was also made of the patient's movements, speech, and functional ability in order to provide a baseline for subsequent evaluation. Further recordings were made after specific periods of time in the patient's stay.

4.4.1.2 Problem identification

Within a week of admission, the Team responsible for that patient held two meetings. In a problem-identification meeting they identified and recorded the patient's strengths and weaknesses, and 'brainstormed' those to be worked on (other problems could be raised and worked on subsequently). A decision was made as to which professionals would be responsible for each problem (several professionals were frequently identified for each), and short- and long-term goals were set. At this stage there was occasionally feedback from various Team members, of the patient's perceptions of his or her problems, and these were incorporated in the problem list as appropriate.

The therapists in the Team met to devise the patient's programme of therapy. This was organised, with reference to nursing feedback, for the times in the day when the patient would be most receptive to a certain type of therapy, and to the length of session which a particular patient could manage.

4.4.1.3 Initial discussions and monitoring progress of the rehabilitation programmes

During the second week of the patient's stay, their case would be discussed at the rehabilitation planning meeting (RPM), usually chaired by the director. Two of these meetings were held each week, one for each Team; all relevant therapists attended, as well as a primary (or occasionally associate) nurse. All new patients were discussed relative to their scores based on first assessment, the initial problems to be worked on, each professional's expectation of progress related to their aspect of care, and the likely discharge date. Twenty minutes were allotted for each patient, and all professionals were expected to contribute.

The RPM provided a regular opportunity to monitor goal achievement. After the first meeting, each patient was discussed every second week for 20 minutes. The director would ask for a progress report on each specific problem, then everyone had an opportunity to discuss aspects of care or therapy.

This was a useful forum to discuss the patient's emotional and social concerns. Since these were not usually defined as problems (as there were no professionals identified to provide this service), this was often the only forum for such discussion. Emotional and social concerns were, however, deemed of vital importance since they impacted on the achievement of goals. For example, at one meeting there was a long debate about a home situation which had broken down after the patient's discharge. His partner had thought she could cope, but this had proved too stressful and the patient had to return to the unit. He subsequently became withdrawn and stayed in his room. The Team debated strategies to encourage him to take part in therapy sessions once more. Where action could be taken in relation to these concerns, a plan was devised and carried out, but they remained the least addressed areas, in a formal, structured sense.

Some information related to emotional and social concerns was gathered directly from patients, or through observation, but their families were also asked to complete a questionnaire relating to past history, current situation, aspects of personality pre-trauma, and, specifically, adverse events which may influence the patient's progress.

At any time during a discussion on a patient, the Team could debate the proposed discharge date. The time allotted for a patient's stay in the unit varied from three months to a year or more, and was related to the progress made. The unit was orientated to goal achievement, so that where patients had reached goals and were still progressing, their stay could be extended. If however, goals were not being achieved, then discharge would be considered appropriate. Finally, this meeting gave Team members the opportunity to express their anxieties about dealing with particular patients.

4.4.1.4 Case conference

Four to six weeks after admission, a case conference was convened to reassess the patient's progress, and give both the patient (if appropriate) and relatives, a chance to ask questions within a formal setting. The week prior to this conference, two meetings were held in relation to progress: during the RPM the patient was re-scored on both outcome scales and all professionals were asked for their views of the patient's progress; where the clinical psychologist had been involved in a particular patient's psychological assessment, a cognitive management meeting provided an opportunity for therapists and nurses to meet with him to gather information and discuss any issues which may be relevant for the case conference.

Usually chaired by the director, the case conference was a process in which each of the relevant professionals presented an account of their work with the patient, and what had been achieved. The relatives, and/or patient, could then ask questions about the treatment and therapy and likely outcomes. During the conference, the proposed discharge date was discussed, so that all felt comfortable with that information.

4.4.1.5 The discharge report

A few weeks before the discharge date, a report co-ordinator would be appointed from within the patient's Team, to ensure that each profession's representative had compiled the relevant section of the discharge report. About two weeks prior to discharge all Team members attended the report meeting to put forward their contribution and to finalise the report. This report was then made ready to accompany the patient on discharge.

4.4.2 Team communication: general information sharing

4.4.2.1 Nurses' handover

In addition to nurses' daily handover sessions, and as a means of enabling the therapists to meet a wider variety of the nurses, a longer handover meeting was held on Friday afternoons, attended by a representative of each therapy. This gave all staff the opportunity to discuss various patients and their treatment programmes or care. It also served a 'team management' function by providing a useful forum for the discussion of aspects of interdisciplinary communication.

4.4.2.2 Written communication

Communication was further facilitated by a number of written records and information guidelines. Most important were the collaborative notes, a innovation introduced in April 1996 and still in the process of evolution. All assessments, problem identification sheets, monitoring of goal achievement, and case conference reports relevant to each patient were kept together as one set of notes. A separate section in the notes was made for each problem identified in the first Team meeting; the problem was stated, its actual or possible antecedents were noted, long-term goals were defined, and short-terms goals which would provide measurable steps towards those long-term goals were determined. Each profession's entries in the notes were made under the appropriate problem section and followed a prescribed formula known as SOAP; this acronym stood for the patient's *subjective* responses, the professional's *objective* observations, the professional's *analysis* of the situation, and the *plan* for future action. Where two professionals had worked together on a joint session, this was recorded as such. All disciplines were expected to contribute to the notes on at least a weekly basis.

At the beginning of the notes, a list of specialist words, and abbreviations had been compiled, with their appropriate definitions. This not only assisted professionals in learning each other's professional language, but also ensured that all professionals understood each term to mean the same thing.

Six-monthly sessions were held for all professionals within the unit in order to initiate new members into the process, and to allow staff to express their views on the system's operation. In this way the note keeping was still evolving. There remained, however, several concerns related to the definition of problems, feelings of ownership of the notes, and the issues of maintaining a dual system by the nurses.

The nurses kept Team books in the nurses' office; these contained patient records relating solely to nursing and medical care and patients' responses. On discharge, a copy of these notes was placed in the collaborative notes. In addition, individual patient records of any conversations between nurses and the relatives or carers related to patient or family concerns were noted in a book; this was also kept in the nurses' office because it was chiefly nurses who dealt with relatives and carers.

A recent and popular addition to the written communication was a handover book. This was also kept in the nurses' office, and all professionals from both Teams wrote in it, to make known any changes in treatment or therapy, or in the patient's condition. It also included requests for feedback, with responses from various Team members. Finally, it contained messages

of thanks between the staff, for example where a particular profession had been short staffed and had been assisted by others.

Although the unit had 24-hour medical cover, the doctors visited for only a short time each day. In order to facilitate communication, there was a GP/unit handover book in which all professionals wrote, with entries largely related to requests for pain killers or laxatives, or requests for certain investigations to be signed for. Although it contained reference to changes in patients' conditions, in general terms, patients were medically stable.

As a final means of assisting communication, guidelines for therapeutic programmes were put on patients' walls and in the nurses' office. These comprised information on such techniques as transfer of patients, and regimens to assist safe swallowing. In many cases photographs were provided to clarify the written word.

4.4.2.3 The team management meetings

All heads of department and the director met weekly to discuss external issues such as health authority directives and current educational conferences, as well as internal issues such as training, recruitment, or suggested improvement of the system. Information from this meeting was fed back to the staff via each profession's own meetings. The therapists met twice a week, once to receive feedback from their head of department and discuss patient management issues, and once to discuss training issues and research feedback; this meeting included their own supervisor, and other therapists from the trust on a regular basis.

The nurses had their own system of daily handovers at the end of each shift, with the midday handover being the most extensive. These handovers were essentially to feed back patient status, but the head of the department or her deputy fed back the outcomes of the heads of department meeting on a weekly basis. They were not seen to have regular weekly educational sessions.

4.5 The ethos of care

The unit promoted an *'interdisciplinary, patient-focused, problem-oriented approach to therapy and care'* (from SLT teaching notes). In an educational workshop for internal staff and those working in other rehabilitation units, staff stated that they had opted to take an *'integrated interdisciplinary'* approach which emphasised joint working, co-operation in the rehabilitation process, and was strongly problem-orientated. The rationale for this approach was that neurological damage created complex and wide-ranging problems, and unless the professions worked closely together, the necessary co-ordination of information and knowledge would not be achieved.

Of prime importance was the fact that each patient received a *'tailor-made' ongoing and consistent* programme of therapy and care based on individual professional assessments and a Team analysis of the problems to be worked on. Therapists and nurses then carried out that programme using single and joint therapy sessions, with nurses providing 'carry-over' and consistency of therapeutic interventions outside the therapy sessions. This ensured that patients received ongoing therapy over the 24 hour period, as opposed to a few intense hours of therapy. Several professionals spoke about previous experiences within rehabilitation units where organisational and educational constraints had severely compromised continuity of therapy. For example:

> *'The nursing staff weren't taught it at all, so that when you came to work and doing your own patients then you'd got an immediate problem working with your patient for an hour during that day doing very specific treatments, and then for the rest of that day they would be doing something completely different, unless you've got nursing, speech and OT who would carry that on as well.'* (PT)

In this unit however, nurses performed handling and lifting according to the principles of the therapy provided. There was good support for the concept of carry-over among the nurses, however the means of achieving the carry-over was often debated.

'Patient-focused' did not, however, always imply patient involvement. While the therapists and nurses often framed problems from a patient perspective, talking with patients about their initial assessments, how they saw the problems, and the likely plan of therapy or care, there was no formal patient or carer input in terms of deciding goals at this stage. The topic of patient and carer involvement had been raised early in the evolution of the integrated approach, but it was argued that patients frequently had little or no insight into their possible progress, and that in the early stages of a patient's stay, relatives may have over-optimistic expectations. However, at a recent training session on collaborative note-keeping the issue had been raised again, and it was agreed that this would be an area to develop.

Patient and carer involvement *was* expected at case conferences (4-6 weeks after admission). Both were invited to discuss progress and care with all professionals involved. These sessions were sometimes difficult since professional and patient expectations could differ widely. For example an electrician, who had suffered a right hemiplegia, was convinced that he would be able to return to his trade, and it was difficult to help him understand that this type of fine work would not be possible. One purpose of this case conference was to attempt to help patients and relatives to address potential limitations and the effects on their future life together.

Carers and relatives *were* encouraged to take an active part in reporting on progress over the weekends when patients visited their homes. A structured questionnaire was provided, in addition to an opportunity to talk through any problems with a member of the Team.

Apart from the therapeutic path of progress, patients and relatives were *always* involved in *ad hoc* and special social occasions. These included barbecues, patients' birthdays, staff or patients' leaving teas, Hallowe'en parties and Christmas parties. Despite the fact that many patients become *'bored'* with rehabilitation, the general feeling incurred by these occasions was that the unit was *'very homely and friendly'*:

> *'There's an expectation and anxiety of what's expected, in this place. You know they are they going to be there for ages, and it's a long way away from home, so there are all sorts of anxieties, and I have often greeted them off the ambulances and it's "we are a bit worried about what we're going to have to do" or "what is it going to be like?". And actually that is dissipated in the first hour they're here. Part of it is they actually see the place, but they discover that there are smiling faces around, and that people talk to each other, and that there aren't strict demarcations between ... you know this person's such and such and this person's so and so.'* (A)

4.6 The therapeutic principles: Bobath

From its days under the leadership of a PT, the unit retained a leaning towards this profession as its primary therapy (in keeping with evidence from other research on rehabilitation units, e.g. Johnson, 1995; Fokke, 1994), and the principles of therapy embraced by all professions to some extent, were physiotherapy-based. The goal of the Bobath (Lennon, 1996) approach was to provide patients with as normal a range of movement as possible given the limitations of their impairments. This meant reducing muscle tone where damage had caused it to increase, and helping the brain to make new links with affected muscle. Although *functional* outcome was an overarching goal, the *quality* of the movement was important to the Bobath concept, therefore, while compensatory equipment such as Rolators was used, it was not the first consideration.

The approach created difficulties both for patients and some other professionals, although many staff had accommodated the principles into their practice. For the patients it

was disheartening to come into the unit walking in a fashion, only to be required not to walk until the muscle tone had been reduced in their affected limbs. The PTs helped patients to come to terms with this by explaining the reasons, and had developed a protocol of progress for them. For other professionals, especially OTs and nurses, independence had always been the primary goal; the *manner* of that independence not being considered as important as the *fact* of it. The OTs had however, incorporated the principles into their practice, and this was facilitated by the fact that their head of department was Bobath trained; her interest stemmed from working with a new PT who had introduced her to the model.

> *'Yes it concerned a patient who was very dysphasic, had a very dense right hemi. I didn't really know anything about Bobath at that point; I was just going along the "independence at whatever cost" road ... A new physio joined the team and we got on, on a personal level very well which was great ... I was explaining to her what I was doing with this patient because he was really frustrated and there were lots of things he couldn't do. But he saw the woodwork shop and indicated that he wanted to go in there, and he was absolutely thrilled and we arranged for him to have a go. And the physio, in the very nicest possible way said "well actually, I'm not too happy about him going in the workshop; I don't know that it would do his tone any good". "Tone, what is tone?" (I was a very new OT) ... She said "why don't you come down and join me in physio and see what I mean?" So that's when I started having some joint sessions with the physio and I said "oh crikey I see what you mean".* (OT)

This quotation fails to express the enthusiasm displayed by this therapist. Witnessing, over a period of sessions, how the reduction in tone allowed the patient to move more freely and therefore more appropriately, was revelationary for her. Of course it was predicated on the fact that she was prepared to learn from the PT, an issue that will be raised later with regard to some aspects of the nursing and therapy relationship.

Since the nurses were expected to carry over from the therapists it was important that they were informed of the basic concepts, and strategies for transferring and positioning patients. While they were *'always willing to try'* to accommodate therapists' wishes, as several nurses pointed out, this was not always easy:

> *'One of the things that can madden all the nurses, trained and untrained is if we're given something to carry over which is not very practical, and the favourite one is the low transfer, and we're trying to do that with someone who needs their trousers pulled down, when you are trying to get them on the toilet ... it's not practical. They have to stand up to do that. And the physios say "you can't stand them up, it will increase their tone". But you have to. You see it is easier to do these transfers in the gym, with its nice smooth floor and the bed at a good level, and they've got lots of space round about. But if you are in a patient's room it is totally different.'* (N)

The PTs sometimes requested that patients did not wash themselves from the waist down as this increased tone prior to the physiotherapy session. This meant that nurses were required to provide this care, adding to their workload. As a result there had been conflict over the interpretation of the principles; negotiation was sometimes successful, and sometimes not. The therapists however, appreciated the nurses' difficulties, and attempted to compromise the principles as far as carry-over techniques were concerned.

> *'Usually, and that's where perhaps we should do it earlier, that's the point where it gets a bit tense sometimes, and that's when we say "we should have a session", and we'll actually go into the bathroom and transfer them, and perhaps work out a compromise. It maybe that they have been doing the*

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technique slightly differently, and that they could try it a different way, if that's easier, and maybe not do it as purely as we would like.' (PT)

Many of the nurses had spent time in sessions with the therapists learning useful strategies to help them overcome their limited circumstances. However, as suggested above, the carry-over of transfers had caused problems, and the comment regarding *'inadequacy'* on the part of the nursing staff in the following quote will be examined later:

> *'There was a patient who was extremely difficult and it did cause quite a few problems with the way she was being moved. I decided to have some joint sessions then, and I think it would have been a lot more useful if that had been done in the first few weeks of therapy ... before it all ... it didn't blow up but there was a lot of tension in the air between nursing and physio. We were planning on having joint sessions earlier in the patient's stay so that we could negotiate difficulties earlier on. And we were saying to the nurses "if you are having any difficulties and you are finding it difficult it doesn't matter, come in and tell us". It came out of this patient that the nurses felt inadequate, and they felt that we could transfer, and if they came into us and said "we can't do it", that they felt inadequate, which we would never think and were really surprised to hear it.'* (PT)

From the orientation package provided for new nurses, it seemed that the nurses used the Orem model of nursing, based on self-care deficit. However, it was not widely acknowledged as a model of care by either the nurses or the therapists, nor was it *essentially* a problem-solving model. Lack of a facilitative and explicit model may have fostered ambiguous perceptions of the parameters of the nursing role and problems with defining nursing practice, which other models may have avoided. For example, although the Orem model would fit with the concept of developing and enabling self-care, other research (Fokke, 1994) has suggested that a more holistic and problem-solving approach such as Roper would be more appropriate and would more readily facilitate nurses to extend their role into areas such as education and counselling.

4.7 Perceptions of team membership

There was wide consensus among staff that there was a central core of team members, made up from the different professional groups. These included the director, the therapy groups, nurses, and, perceived particularly among the therapists, catering staff. People were asked to draw their representation of the team, and many used images such as flowers, jigsaws, circles of people holding hands, and spheres in order to describe the integrity of the team. There was a general perception that this was required in order that patient therapy and care was as consistent and co-ordinated as possible.

The patient was only present and central in about 40% of the drawings, giving an impression that the patient was 'done to' rather than part of the team; in many of the other drawings the director was central. On discussion, even those who had placed the patients as central to the drawings commented on the importance of the director, describing him as *'a strong leader'*, the *'glue'* of the unit, with *'his finger on the pulse'*. His role as leader was seen by many to be to be fundamental to the strength of the team; this is explored later.

Despite this apparent unity, on reflection, most people acknowledged that it was to some extent an ideal image. They felt that communication between the nurses and the therapy groups was not as effective as it was between the therapies; as such nursing was seen to be slightly separate.

> *'But I think because the communication isn't as good with nursing as it is within therapy disciplines, it doesn't feel so much like ... you know physio's one leg, OT's another leg, speech is one of your arms, and nursing doesn't feel like one of your limbs, it feels slightly detached, and I think*

that's due to communication, but it could be due to the [collaborative] note system.' (OT)

The perception of dislocation from the nurses was the source of much comment among team members, and possible reasons are discussed later. However, this feeling was relative, since many people across the professions also spoke about the way in which the team was more cohesive than in any other place they had worked. Further there was an impression that the relationship between nursing and the therapies was improving which was related to improved communication structures:

'Sometimes in the past it has been quite difficult to actually communicate what you want to happen in positioning say, to one person, because there are so many nurses to communicate it to. But we are still evolving as a unit, so those areas are being addressed even now. We've got the handover meetings with the nurses, and then there's the book now which works extremely well.' (OT)

The inclusion of catering staff in the images was interesting since they might not necessarily spring to mind as part of the 'caring' team. However, these two people were perceived to have a very important role:

'Oh they give us advice on all sorts of things. I mean communication-wise they might say "well so-and-so's sitting on a table on their own and they are not able to say what they want" And they watch in the evenings. Or they say "you should see him when his brother's here, laughing and chatting, you should get his brother in" or "he likes a joke", and swallowing wise they are really switched on. They'll say "oh we noticed just that slight change in texture, gave difficulties" or whatever.' (SLT)

Although nurses were also present at mealtimes, supervising feeding programmes, it seemed that, particularly for the SLTs and OTs, the feedback of the catering staff was as valued as the nurses' feedback in this respect, and reinforced perceptions of *'respect for others'* as a team value.

In terms of defining team membership, people also spoke of belonging to their own professional groups. While this was of obvious importance in terms of their professional knowledge and education, allegiance seemed to be associated equally with the Team as with their own profession. This seemed to relate to the way in which patient-focused working directed professional practice:

'Because everyone is so involved with that patient; it's a general interest about that person. Whenever anyone can help they will; there's an awful lot of sharing of ideas, sharing of anxieties about patients, sharing even things like "oh I had a brilliant session with so-and-so, you should have seen it". Often one of the therapists will say "come and look at this", and call you over, and I think that is part of having the joint notes it has brought us all together a lot more ... having the notes and reading what somebody else has written, then it makes you share.' (PT)

The more peripheral roles within the team were seen to be medical cover, the clinical psychologist and the SW, indeed many people left the GPs and the clinical psychologist out of their drawings until further discussion had occurred; when talking through the drawing of the flower, one participant decided to draw the medical cover as a bee alighting on one of the petals. This perception was not acknowledged to be a problem by the therapy groups, but it did create problems for the nurses, because they put a stronger emphasis on the medical input by virtue of their role they took, and because they felt that communication between the doctors as a group was ineffective. Finally, it was perceived that the nurses were forced into a more directive role than they would have wished as a result of the small amount of medical input.

'The trouble is they are not communicating with one another, and the situation to us is no better than it was before, because we are the ones who are dictating more or less the medical input, which is wrong. We're saying "do you think this guy's tablets need changing to this". We're doing all the proactive work. All they are doing is writing prescriptions and writing a few notes. I would want them to know the patients, basically. To know them and know that this guy's got a subarachnoid haemorrhage, he's got hypertension and to be worried about him. It shouldn't need us to tell them. On a hospital ward, the SHOs, or whatever they know the patients. They wouldn't thank us if we said "don't you think he needs those tablets." (N)

The nurses generally felt unsupported, and although patients were supposedly medically stable, the nurses were still responsible for 'medical' (nurses' definition) as opposed to therapeutic care, so it was not surprising that they looked to doctors for support. This was seen as a double-edged sword however, because some nurses also resented their interactions with the GPs, perceiving themselves to be treated as 'handmaidens'.

'Like with the bloods; they have to have a nurse with them, and they have to have the trays set up. And that went out years ago, and I don't think it's relevant, and I don't think it should be happening.' (N)

The clinical psychologist was frequently drawn, as an afterthought, at the extreme edge of the page, or on one occasion on the other side of the page. This relationship was strained during the study and is further explored later, as the situation demonstrated the effects of a person with different views of teamwork joining a tight-knit group of professionals with similar values and beliefs.

Many people had difficulty in ascribing a position to the SW. Those employed in the unit for some time remembered when she worked many more hours and was able to fulfil her role more comprehensively. They commented that her position was then much more central, and indeed there was a strong feeling that she should be, and in some ways was, still a central member.

'Oh yes she's part of this one [pointing to the central team]. She has a vital role in the longer-term management of people, and as OTs we have a lot of joint work. But because she's so part time it is difficult to access her, and I think it's frustrating for all parties, the patients, us and her.' (OT)

It was generally acknowledged that her current peripheral position was only enforced by her lack of availability, since she was not privy to most meetings and discussions about the patients. There was a widespread perception that her lack of social work and counselling input created a big gap in the rehabilitation process.

'And it must be incredibly hard because ... just because she's not here it doesn't mean that she doesn't recognise the need, but trying to meet the patients' needs, because she used to have the capacity to do a fair amount of counselling as well as all the practical things; the form-filling and the benefits. And now she just has to prioritise certain aspects of her work. And so the counselling aspect of her work she's not able to give as much as she would like to that.' (OT)

4.8 The team culture

One of the most striking aspects separating the majority of the team from the more peripheral team members was their highly developed *awareness* of being 'a team', and the values which they all held to be important in order to function effectively. Being a *'team player'* was seen to be almost as important as being a skilled professional. It was considered vital that not only did people espouse the beliefs, but that they put them into action in every aspect of work.

This team functioning was evident across the unit's customs and rituals, the way in which documentation was produced, and the way in which people interacted across the professions.

4.8.1 Customs and rituals

There were many occasions where the whole team came together to display solidarity, for example, saying good-bye to a member of staff was a 'whole unit' enterprise, with patients and staff having a tea in the dining room. Presents were given, and those who felt moved to do so, gave speeches. The way in which the director 'homed in' on funny or embarrassing incidents in his speech was a source of much joking among the staff, but reinforced the importance of his place in the proceedings.

Many people socialised across the professions. Also, until the previous year, the unit had closed for two weeks around Christmas, and during that time there were 'whole team' training sessions and discussion about the financial status of the unit and possible direction for the future, in addition to within-profession teaching.

In a deliberate attempt to reduce professional discrimination it had been agreed that all staff would wear the same type of outfit. The style was very casual, comprising navy blue sweat-suit bottoms or shorts, and any plain collared T-shirt. These outfits were practical for all kinds of work, and were generally well accepted (but it is interesting to note that they were representative of physiotherapy uniform). Comments about the outfits suggested that they reinforced the more *'homely atmosphere'*, and presented a unified front to the outside world.

4.8.2 Team documentation

In terms of documentation, the language of the unit revolved around the team approach. All public relations and information documents for patients stressed the interaction of the team as the way to provide optimum therapy and care:

> *'Rehabilitation at [unit] is based on two fundamental beliefs: that for maximum effect rehabilitation should be a team process.'* (Promotional booklet)

Programmes of therapy were worded so as to emphasise the 'teamness' of the activity. For example *'Team Programme for X – Safe Swallowing: it is suggested that <u>we</u> should do ...'*

The chief example of team function related to documentation was the collaborative notes. The process of developing this system had also been team-orientated; the idea was mooted by an incoming PT who had observed the system in her previous hospital. Asked how the system had worked she said:

> *'Very well, so my experiences were good. I mean I found them really hard when I got there; I hated them because it was so difficult to get your head round this idea, and the goal setting is quite difficult, but it helped me develop myself as a physio and my treatment plans, and my goal setting, and they got better while I was there, and that's why I thought it was important in order to develop all of us.'* (PT)

The director felt that it would *'set the seal'* on the teamwork ethos, and a meeting was called with all the heads of department. Each head had taken the idea back to their profession and requested opinions and ideas. A general meeting was called in which people expressed their reservations or enthusiasms for the system; these were discussed and resolved where necessary. However, difficulties remained with regard to the nurses' acceptance of the system. In an attempt to overcome the *'language differences'* of several professions writing under the same section, sessions were held with representatives of all professions to identify the meanings of profession-specific abbreviations and acronyms and to identify whether apparently shared abbreviations or phrases meant the same thing across professions. The resulting list of definitions was placed at the beginning of every set of notes.

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The notes were kept in a central room where people were expected to spend time each week reading and writing them up. The use of a special room was felt to be symbolic as a *'team place'*, since professionals knew that in other units operating the same system, the notes moved around, making access more difficult.

All *therapists* were extremely positive about the way in which the collaborative system had shaped their thinking and refined their practice, both with regard to the fact that they were collaborative, and because of the way in which they were problem-oriented:

> *'Yes, because it makes you aware and watch your back a bit because you know that somebody may look at what you've written. I mean you could in the past but it's more open now and it keeps you on the ball, and it keeps you thinking "what's my next goal, is it patient centred, is it functional?" I think it is a step forward, just the idea that it is in a central place, and the fact that people can look at what you have been doing easily.'* (SLT)

Many nurses however, were ambivalent; on the one hand seeing the notes as a *'way forward in terms of team-working'*, but on the other hand feeling that their own note-keeping had been usurped in favour of *'therapy notes'*. In their conversations collaborative notes were *not* mentioned, whereas it was common among the therapy groups to talk about the benefits of the system. Differences in perception are discussed later, since it was related to the way in which nurses viewed their role in the unit.

4.8.3 Interprofessional Interaction

The basic assumption for people working in the unit that one had to be a *'team player'*, was evident from the first selection interview:

> *'She asked me about where I was working before, were there issues around role divisions in the team, and was there a lot of overlap among the professionals, and how could you get round the issues.'* (OT)

It seemed that staff were recruited not only by virtue of their professional skills and abilities, but, almost as importantly, for their ability to *'fit in'*. This factor was identified by the director and backed up by professionals from several disciplines.

> *'It is vital for me that I can assess how open they are likely to be; to look at their aplomb in dealing with emotional issues. I like to test that out because it is important for people to be able to let off steam at meetings, so I ask them questions they might think are off the wall about themselves as people.'* (D)

Although the following comment sounds rather unforgiving, it was said in a positive manner to describe how important the team felt their culture was and that it needed preserving:

> *'... and you've got no choice either. It's not like you can either do it this way or that way, this is the way you do it and this is the way it works.'* (PT)

When talking about the team's difficulties with one of its new professionals, and what the team should be saying, one person commented:

> *'Very much about "this is how it is done, and this is how it will continue to be done" ... But it's a structure that works for us, and so [that professional] is going to have to fit in with that.'* (OT)

'Fitting in' encompassed a way of being with fellow professionals that optimised the highly-structured communication system. Above all people were expected to be open and honest in their negotiations with others.

> *'I think it's probably, and this sounds a bit creepy, but I think the director and all of the people in head positions, all breed the right feeling, they all*

breed this feeling of being very direct, "communicate, go and talk to someone face to face, deal with it there and then, don't put things off, don't give mixed messages, be direct, be honest, be straight with people".' (OT)

The following long quotation by the director describes an incident which epitomised the open way in which difficulties were recognised, raised, handled 'safely' in terms of professional esteem, and overcome, so that all felt they had been listened to:

'It was a fairly speculative admission because the severity of his injuries was such that he didn't look as if he was going to go far. And I said, "well we will see where we can go, but then you let me know how you feel about his prognosis". And there was a meeting, and the view from the floor was that we were probably not going to get that far with the patient. On the strength of that, rather than actually hang on to him for ever, we would make arrangements for him to go back to the hospital ... We had the case conference and I went through this with his mother and his sister at the end ... And the next week at the rehab planning meeting there had been a change ... in people's view of what should happen to the patient, especially from SLT. He had actually started to make some changes in the way he was responding to questioning; he was starting to elaborate a little. And I said "there is a change here between this week and last week; what you said last week was this". And it was the same in the case conference, the same message came across; "we're pretty definite about this". And I said "right, that's the message that I reiterated and that's the message that I worked on". And it was as if, at the time, they had actually felt rather scared of their own dogmatism, and they kind of back pedalled. And I said "right, what do you want to do about it?" ... And what SLT wanted to do was actually to keep him on. What was evident, just from the feelings in the meeting was the tension about what happened next. They'd actually made this decision, and yet there were people here who wanted me to change that decision. And it felt very much as if they were just waiting to see how I was going to jump; whether I was going to say "you've said what you were going to say and I'm not going to back pedal on that. Within the next month I'll see to his transfer". And I think that would have been accepted, but they would have been unhappy about it. And what I said instead was "it feels as if there is quite a lot of tension about this, we need to talk about it; get your diaries and we'll sit down and talk about it". So what I did was to just get the team that were in the case conference, together, and I went over it with them. And I said "this is what was said, is this what you meant". And it was evident that it wasn't how they had actually delivered what they'd said, and it was an interesting slant on the group process about who delivers what. Physio delivered a message that was pretty hard-nosed and will be; theirs hasn't changed; the patient is always going to be severely disabled and never likely to walk. But SLT had been less so, but it was like there was a cascade effect that I was aware of but hadn't appreciated at the time the import of it; certain people delivering it ... Physio spoke first, so it was like being the pace setter. But remember this didn't come out of the blue; we had talked about it beforehand, and we had talked about it prior to the case conference. But the thing that I knew was that there was tension there about it; there was unhappiness about what might happen to the patient. But, the thing that I knew I had to deal with was the tension; I had to resolve it somehow. So what I needed to do was to give people the space to talk about and not feel threatened by what they had said, or have

any feeling that they had to recant or retract in any way. At the end it was evident that at the end, at least cognitively, they wanted more time with him. And I said "OK, if you want more time with him then we'll do it. You know, he's a young man with a head injury, he's only 31 or something like that, we'll give it a shot". And I checked with the others and it wasn't a problem ... And there was just this tangible relief. It was partly to do with "we're not dumping him", partly to do with "yes I need to check that out just to make sure I am saying that he's not going to go any further, or if he is then I need to pursue it a bit".' (D)

Openness encouraged the sharing of information and knowledge, and speaking about anxieties, both related to patients' conditions, and professionals' feelings of pleasure or inadequacy in dealing with them. For example, in a meeting which included members of all professions and the director, a therapist was talking about a patient who was becoming upset at her lack of progress. The therapist was also finding this difficult to deal with and became rather distressed. She said *'how do you comfort someone who is making an accurate statement'*. The director agreed that it was difficult but that one of the worst things would be *'to pat her on the head'* as it was not an honest way of dealing with people. Another therapist agreed that the patient's feelings were not easy to manage and offered a strategy for allowing her to share her emotions by saying *'you could reflect back to her what she is saying to you and let her talk about her feelings'*; this was discussed with the nurse in the Team. The director added that it might be useful to *'keep success and failure out of the conversation'* and gave an example of how the situation could be dealt with in a more neutral manner. The therapist thanked those who had contributed ideas and said *'I don't feel so bad now, because I know that you feel the same; I don't feel it's just me now'*.

This scenario was particularly useful for showing how the expression of anxieties and providing coping strategies was encouraged by the director. This reinforced his position as an integral member of the team, and someone to whom one felt safe in displaying these feelings.

Another team expectation was that the therapy groups would 'slot into' the timetabling system whereby sessions were carefully arranged in negotiation with other therapists. The weekly sessions where these timetables were worked out often resulted in *'fairly heated debates'*, but a conclusion which suited both patients and staff was always reached. No one profession took 'centre stage'; they seemed to take turns to alter their programmes, with comments such as *'it's your turn to change, we've moved twice now'*.

'Fitting in' implied that professionals were expected to work *with*, and not just alongside each other. Joint sessions in which any professionals could reserve time to work together on a particular aspect of patient therapy or care, were common. One example showed clearly how this practice could enhance the therapeutic intervention. A man who had suffered from a stroke and was subsequently dysphasic also required physiotherapy to his lower limbs. In order to obtain his co-operation, the PT needed to elicit some responses from him, and asked the SLT to join her. By using cueing strategies (for example helping him to say the first letter of the first word), the SLT was able to encourage the man to respond where required, and so enabled the PT to work with him as she had desired. The PT also made a point of learning the cueing strategies and so was able to use them herself for subsequent sessions with the man.

To be a 'team player' also meant that professionals were expected to respect each other and patients within the unit. Failure to do so met with disapproval from all, as was seen clearly when a new professional joined the unit. As with many aspects of what it meant to be a team player, people felt that they articulated these feelings more strongly when they had someone in their midst who obviously was displaying non-team behaviour:

'And really, when [the newcomer] starts saying things about a patient that you've been working with for 10 months, and says something you don't agree with because [the newcomer] has only seen them for a one hour session, and does it in an opinionated manner, you begin to think "what

are you talking about, don't you respect that you may not have the whole picture and that there's whole core of people who know this patient in all their aspects ... how can you make these decisions when you don't know the person".' (OT)

For most team members, the way in which they spoke about fellow professionals emphasised how much they valued them.

'It's an ability to talk to somebody, if you are having problems with somebody, or the good things; sharing everything, sharing the knowledge, and being willing to help other people if they have ... and this is teamwork ... and you act as an advisor, as say a companion.' (PT)

In this last quote the word 'companion' has been underlined because it seemed to sum up the perception that the *therapy* groups had of each other, and the way they valued each other's input. This style of talking about team members was not *generally* the same when talking about the nursing group. It seemed that 'respect' in relation to the nurses was interpreted as 'caring for' or accommodating. As such, some members of the therapy group felt that 'respect' had translated into patronising behaviour, and that this was unhelpful to the nurses who were already feeling unsure of their role.

'Fitting in' also meant that professionals were required to constantly evaluate their own practice, and as a group to find ways to improve the system. The 'system' was perceived as always evolving, and all staff were expected to offer advice and opinion on how to change things if they felt they were not working to the benefit of all. For example, a junior therapist had joined the staff the previous year. After attending the rehabilitation planning meetings on a few occasions, she noticed that it was possible for one person to hold 'centre stage' for long periods without any decisions being made, and without sufficient input from other professionals. She raised this at one of the meetings; it was discussed, and a tighter agenda for speaking in turn was devised which was not only popular, but felt to be a more effective use of people's knowledge and time.

Another example was the six-monthly review and training session of the collaborative notes system which, at the time of the study, had been in place for 18 months. Two thirds of the review was given to updating new staff, and a third to debating difficulties rising out of practice. Two of these sessions were observed, and fundamental issues, such as the defining of problems, were raised and discussed at length.

It was expected that people approached verbal information-giving in the same efficient way as was expected with the written information-giving in the collaborative note system:

'And I noticed that I was conscious of changing the way I use language. For instance in the rehab meetings I felt that I needed to be more efficient with my use of language; so that when I had my little bit to say, I had to say it in a nutshell. Not a sound-bite which was what I was used to in my last job. There I used to have to say to the consultant "did, did, did" in one sentence because they wouldn't have time for any more. Here I had to have an effective use of language, but I had a bit more time to pad it out. So it would just be efficient language really; I had to be a bit more to the point. And again that comes back to the feeling that the director and the others breed down to us, this thing of being to the point.' (OT)

A final requisite of 'fitting in' was that professionals would share their knowledge and skills with others and that these would be actively sought by all:

'If you work on your own you can get stuck into your own role, and your own ideas, and you don't learn from it ... you can always learn more, and so learning from others ... and their help with the patient's progress,

there's always something you can do to assist one another. So with speech therapy, if the ST knows that short sharp commands, short sentences that patient understands, then you're not going to talk and talk in long sentences and ask loads of questions in physio.' (PT)

It was expected that while these skills and the knowledge base would essentially remain the province of particular professions, sufficient would be shared to enable all in the Team to have a large area of common ground. Many staff spoke about their main function being as *'enablers of the patients'* rather than wanting to promote *themselves*. For this reason they felt that whatever was required of them, if it was beneficial to the patient then professional divisions of knowledge or skills were not appropriate.

'We all need to come towards the patient, not all take a little bit away from that patient and work on it individually. And that's one of the main things that I like about here, and I don't know how easy I would feel fitting into another unit where that didn't happen.' (PT)

There were two main outcomes of this culture which could be seen as beneficial both to the professionals and the patients. First there was the growth of Team knowledge, both with relation to the patients and about each other; second there was the assumption of a learning environment, seen to support professional development. Acquiring knowledge of other Team members' personal attributes, skills and expertise encouraged a high level of professional and collegiate trust among some groups.

4.8.4 Team knowledge

Sharing a body of knowledge from across several professions allowed a more holistic picture of the patient to be comprehended. This was associated with both *behavioural response* and *personal disclosure*. The first aspect was related to the fact that patients' responses within a certain setting and under certain circumstances may be different from that in others, as the following scenario identified.

At a rehabilitation meeting, two therapists gave significantly different FIMFAM scores for a patient's problem-solving abilities. The director asked one therapist why she felt the score should be so low. She described how the man had been unable to manoeuvre between his wheelchair and a plinth to do a 'low transfer' sensibly. She felt that he had a poor ability to think the manoeuvre through. The other therapist was surprised, as the man had performed well in formal assessment. The first therapist reflected that it may only be in physical situations that the man had difficulty in conceptualising appropriately. As a result of this discussion, the two therapists decided to book a joint session in order to examine more closely how different settings might affect the man's cognitive skills.

The second aspect was derived from the particular relationship which professionals such as the nurses were able to develop, given that they were available to patients during quiet reflective moments and intimate situations when the disclosure of certain aspects of feelings and thoughts was possible. In talking about the nurses' role outside therapy hours one therapist said:

'[They] are very good at picking up people's moods, whether they think somebody is depressed, so they would notice and particularly recently they are the first ones to say that they need clinical psychology input of some sort, antidepressant or whatever.' (SLT)

The constant nursing presence meant that nurses were available for carers and relatives who wanted to unburden themselves of worries. In one rehabilitation meeting a nurse was talking about a patient who had been taken back into hospital having had a major fit which resulted in a considerable reduction in his cognitive skills. She described a long conversation she had had over the weekend with the man's wife who had wanted to express her feelings

about the impact this had had on her. For example, she was worried about her decision to take a holiday. The director decided that he would telephone the wife and ask if she would like an appointment to see him. This was arranged and the director was able to help the wife reach a decision, and gave her a means of addressing this with the patient.

The knowledge accrued from both of these aspects enabled the Team to develop an understanding of the patient in the context of therapeutic and care interventions, in their relationships outside the unit, and in their potential future life after discharge. As a result it was seen that far more *'accurate and appropriate decisions'* could be made regarding the rehabilitation process.

Of concern for the staff, however, and in keeping with their respectful relationship with the patient, was the issue of confidential disclosure and its place in Team knowledge. As the following quotation identifies, it was also necessary to define the limits of knowledge dissemination:

> *'And we did have something when I first came here about needing to discuss how open we were going to be, although we work in a Team, there might be situations where a patient may say something to a member of the Team confidentially. So this person had told someone what they wanted to be confidential, and then the therapist had said to (the director): "I'm not sure if I should be letting you know this because the patient told me confidentially". The director then brought it up at a rehab meeting. The problem was then that a therapist who had only been working here a short time went and said it out in the gym, but before it had been possible to say to the patient: "you know that was within your Team". It really came out cold, because it hadn't come up before, but it was fine; it was all handled OK, but that was where it was decided, that if the Teams are ... it's done in Teams at the rehab meetings, so if there's something you've been told that is relevant for the others, then it will be discussed, but that patient must know that only the Team will know.'* (PT)

Under these circumstances 'team knowledge' was defined by Team and not team.

4.8.5 The learning environment

Sharing knowledge, evaluating practice and *'moving the system on'* were important team values. This dynamic culture relied on openness of practice and willingness to be observed. In order to practise in such a fashion it needed to be safe to inquire and to express ideas which may be felt to be *'irrelevant'* or *'silly'*:

> *'You are allowed to make mistakes; ... you are given a lot of responsibility as for example in "how long is this person going to need" or whatever. When you first come here you think "how could I possibly know that", that's such a huge decision. But you know that when you give your opinion, and obviously you need to back it up with some evidence, you know that later if you want to revise that opinion you can, and people won't say "oh you got that wrong" ... As long as you have got reasons for things then that's OK. You are allowed to do that, and you feel that you are allowed to do that, you don't feel silly doing it.'* (SLT)

It could be argued that *across professions* it would be a less threatening action to take than within one's own profession. However, difference of status (across professions) would make it less appealing to admit lack of knowledge. In the unit those in senior positions felt it was part of the integration process for newcomers that they themselves should be seen to be acting in a similar fashion:

'I think it's important as well, that it isn't just the juniors that are seen to be doing the asking, it needs to come from the seniors; like the director will say "what are you talking about, what does that mean?". And I have to ask quite a lot. But that will then encourage anybody who is new to do that, because they will think "oh well they are as daft as I am".' (N)

This type of disclosure was observed on many occasions during the study, both across and within professions, and from the director himself.

Where professionals felt able to learn from each other, where they had watched other's practice, and had developed programmes of care and therapy which had positive outcomes for the patient, there was a high level of trust. This was most frequently perceived between the therapy groups, within professional groups, and between the director and all groups, and perceived less frequently between the therapists and the nurses. Those who spoke about trust, spoke also of its corollary of support:

'It's very much a supportive role of each other. Often it's quite stressful with the patients we have, and we find, not just between PT, OT and SLT and nursing talking to each other about difficulties you've got with a patient, but if we're finding a particular patient upsetting because of their very poor condition and prognosis, or if you've been working on somebody for ages and they just don't seem to be improving and you're thinking "what on earth am I going to do with them next", we chat to each other to offer ideas, or ... well just generally supportive. And everybody knows when somebody isn't happy about something, because we are always chatting and laughing about things, and if you are a bit quiet, somebody immediately pounces on you and says "are you all right?". And that really helps.' (PT)

Overarching this culture was a sense of enthusiasm for the work and the workplace:

'Perhaps I get too involved in it, but I love what I do, and I want the best for my patients so that I can feel that within that patient's stay, I have thought out every possible option, while increasing their activity in such a way.' (PT)

Although this level of motivation was not universal, it was strong enough to create a positive feeling of *'we can make a difference for this patient'*.

The strength of the team culture was such that perceptions from one professional about an incident was shared by others. They ascribed the same intentions, actions and responses to situations. One therapist made the following comment to describe the feeling of belonging to the team:

'I mean you have to watch yourself, but you can more or less say anything because you know that the other's are the same; it's a bit spooky now when I think about it; it's like clones. I hadn't thought about it but ...' (SLT)

4.8.6 Team integration

It has been suggested that professionals were actively selected to 'fit into' the unit, a powerful tool to enable smooth entry for newcomers. Three new members joined during the study and for two, this process appeared almost seamless. In common with others' perceptions of the integration process, both of them felt that people *'reached out to me to make me welcome'*. This 'reaching out' was both formal and informal. New members were involved in an induction procedure where they would discuss with the head of their profession the way in which they worked in the unit. They would also attend a series of meetings with the other professional groups to discuss how they each slotted into the rehabilitation process, and the expected working relationships between the roles.

Informally the process of inclusion entailed finding out and using the new person's particular skills. For example one new and junior therapist had previously worked with comatose patients and had learned coma stimulation response techniques. She described how the team used her skills to help a non-responsive patient to communicate:

> *'It's with the patient who is not communicating at this stage, so I have talked with an SLT about the work that is going on at [another rehabilitation unit], and how to establish a yes/no response. And we have been going through the process of establishing a yes/no response, and we have gone through the assessment form. I have been able to give them some information on coma stimulation procedure, and the assessment they would need to go through ... It has been really nice because we have done some joint sessions, and they have said "is it OK if we do a little bit more, and you observe us, or help or feedback" that sort of thing.'* (OT)

The director was instrumental in the inclusion process as he regularly asked for new members' opinions and would encourage discussion as to whether new action needed to be taken as a result. This gave new members a feeling of value, as they were listened to as if they were already *accepted* team members with established credentials of expertise.

4.9 Perceptions of role

4.9.1 Integrated working and role boundaries

The unit's strong team culture assumed a high level of integrated working which relied on three factors:

- that professionals were prepared to *demonstrate their skills openly*, so that all team members had access to their working practice
- that professionals had sufficient *role clarity* to know precisely what their contribution was
- that professionals were prepared to have *'fuzzy edges'* to their roles, that they were prepared to work across role boundaries where necessary.

4.9.2 Displaying skills openly

Within the hospital setting many professionals operate behind closed doors or bed curtains. For those coming from this type of environment, the unit seemed initially quite intimidating, since much of the therapy area was open to all:

> *'Although it is lovely to be working in the gym or whatever, I felt quite self-conscious up there. You know everybody could see what I was doing and nobody had ever seen me before, I had been able to hide behind a door. Because as an SLT you don't work like that very often ... you draw the curtains and hide behind it ... which is obviously a weakness. So it was quite difficult coming into such an open place, and I had actually forgotten all of that.'* (SLT)

However, there were several perceived benefits to this way of working.

- It provided a quick means of learning about other professions' practice, enabling professionals to understand how they could 'slot into' programmes of therapy:

> *'I mean what are you actually assessing when you are an SLT on your own, or if you don't have a physio there who can facilitate the physical responses, pointing or whatever. Or in physio if they are working on learning the components of an action, you know stand to sit or whatever, and that client can't understand them or can't remember them, and it*

looks like they just can't do it physically, then what is actually going on here, you can't see it unless you've got different disciplines involved, different bodies of knowledge.' (SLT)

- It raised confidence among new members since they were able to learn skills appropriate to their own profession
- It enabled patients to see professionals combining their skills and expertise, not only in their own case but for other patients as well.

This reinforced the team approach to patients. In other cases studies, while patients understood that several people were working together on their behalf, there was little evidence that they perceived the negotiation between team members. In this setting however, the information that patients received before coming into the unit was made plain to them in the process of care and therapy.

4.9.3 Clarity of role

Among the therapy groups there was generally a strong sense of knowing exactly what their role was and how it fitted with other roles; this was recognised by the director:

'And it's as if each department has its own confidence in what it does, and it doesn't have to apologise for it. I mean I occasionally pull the leg of the SLTs about what they do, and the OTs that all they think about is toilet seats, and the raffia Mafia and all that sort of thing; they groan, but they know what they do, and they know what they are good at.' (D)

Several therapists spoke about the fact that they felt able to provide the service for which they had been trained, using the skills they had been taught:

'It's a lot easier, because you've got a lot more nursing staff... to patient ratio. You have the time here, because of setting your own timetables, to plan teaching sessions if you want to, so that you can bring the nurses into the sessions. You can work in the patient's rooms maybe washing and dressing in the mornings, the patient's, with the nurses so you can see how they have been doing it, and if perhaps you would like them to try a different way.' (PT)

The one grey area where some junior therapists had problems with defining their role was between speech and language therapy and occupational therapy regarding cognitive assessment and subsequent therapy planning. Both felt it was within their remit, but in general terms it would be for different reasons. For example SLTs would do language recall or word discrimination assessments, and OTs would do attention and perception assessment, where there was a clear reason for doing so. However, this was not always the case; brain damage often created a confused picture where there may be memory problems, which could relate to either language or attentional problems. Although several members from these professions spoke about the issue, it was not seen as a major problem if knowledge limitations were recognised and communication was good:

'I've learned a lot on the job, and I feel quite confident about memory and explaining to a patient how memory works and how they may be able to help themselves. But I don't feel confident about structuring it and coming to an end point. Traditionally that is the OT's role and they are trained in it. Fortunately the OT I work with is very methodical, and what tends to happen is that I underline her work with language-based work, so if she's using categorisation and memory strategies, I'll ensure that the patient is linguistically able to do that.' (SLT)

In general, the junior staff would refer to a more senior member of their own group for guidance, then negotiate with the other professional involved. This was readily resolved, partly because they were always negotiating at the edges of their roles anyway, and partly because of their senior colleagues' response:

> *'Yes and that's when you need the help of someone more experienced to go to and say "what do I need to do here". I've noticed that [OT] and I keep going to our bosses and come back and say "I've just had a chat with [SLT head]", or "I've just had a chat with [OT head] and this is what they say". They usually say the same kind of thing, which is good. So we share.'* (SLT)

4.9.4 Fuzzy boundaries

Because working across professional boundaries was so entrenched in their practice, it was sometimes difficult for professionals to articulate that they actually operated in this fashion. When asked a question about this type of practice, one therapist replied:

> *'It's funny and I find it difficult in a way to answer that because we just do it, it's not something we think about having to.'* (PT)

However, operating across professional boundaries was fundamental to the ethos of therapy and care since *continuity* and *consistency* were seen as the key factors. Through their joint sessions, therapists and nurses not only worked on the same aspect of a programme together, but could also learn techniques and strategies from each other which they would then use when operating on their own.

4.10 The influence of roles within the team

4.10.1 The inspirational leader

> *'He's the kind of ultimate role model of how we should be working.'* (OT)

As several references have suggested earlier, the director was perceived by almost all participants as a strong and facilitative leader, and was seen to have been instrumental, along with several heads of department, in creating and ensuring the continuation of the team culture. His keyword was *openness* and many other aspects of the culture sprang from this value. For example, he instigated a team session where he discussed the financial position of the unit and its likely future direction. In doing this he made clear the difficulties of his role, helping people to understand why he sometimes made unpopular decisions. He believed that people were more likely to 'pull together' if kept informed, and if they were included in the decision making process. This was reinforced as a helpful strategy by others:

> *'So what it did was to give you an insight into the things you don't think about beyond your own job and department, and you think "who's paying for all this?".'* (N)

He was perceived to have acutely focused antennae which picked up staff problems. Having done this he was seen to respond, and to discuss potential courses of action. Unlike many managers he was not seen as giving 'lip service' to team management, but acted out the principles and let people see that their opinions and ideas could result in changes to practice.

One of his strongest attributes as perceived by others was awareness of his own limitations; he knew what he knew and did not hesitate to ask for guidance and advice where he was unsure:

> *'I don't think he ever pretends he's a clinician, he doesn't take that role on, and maybe if he did then I think we would find that quite hard. We know he isn't and he knows he isn't, and that's how it works.'* (PT)

As such he *'set the pace'*, in his own words, for people to ask questions in order to expand their own knowledge. Because of his self-awareness there were no qualms among the professional groups as to his assessing patients for admission. People felt they could trust that he would call on their professional opinion as required.

Some nurses, however, felt the lack of medical leadership. While they all spoke about the director's strong leadership and facilitative style, some expressed the wish for a consultant to lead the unit, which may have also been related to their perceived lack of nursing support:

> *'And because there are times when you want professional or clinical leadership, then of course he cannot give that ... For example ... we had someone come in on a controlled drug. Well, we hardly ever use those here at all. At night-time we have one trained member of staff and we have an untrained member of staff, and we were unclear as to how we were going to administer this drug. It would have been nice to have had somebody local who could have advised us on that ... we were able to go to the Royal College to find out, but it seemed rather bizarre that we had to do that, to find out what the policy was.'* (N)

His ability to manage people so effectively gave the director a large store of 'credits'; having acquired such trust and respect, he would have had to behave out of character for a long time before people would change their views. A situation developed during the study (see below) which he perceived would test his leadership, and which had not been resolved by the end of the research.

4.10.2 The outsider

The appointment of one new staff member had occurred three months prior to the study. This was a new role but one that *'has been waited for, for a very long time'*. Staff had hoped that this new expertise would give them new direction with patients who, for example, were not responding as anticipated.

Many staff acknowledged that expectations of this professional were probably too high, since this amounted to hoping *'that [the newcomer] could wave a magic wand'* and provide all the answers to the difficulties experienced. However, the new member also displayed antithetical behaviour as far as team-play was concerned, something about which there were also high expectations, but which staff did not have the same willingness to accommodate.

This newcomer seemed as different from the team members as it was possible to be; with a philosophy of working far removed from that of the team. Team members were used to sharing and discussing all aspects of patient care and therapy, and their anxieties. The newcomer remained silent, not commenting on actions that were taken, nor writing in the collaborative notes other than a signature when a patient had been seen. Indeed, any note-keeping done by this newcomer remained within the professional's domain.

> *'I have realised that [the newcomer] does have a couple of eccentricities; one is a reluctance to record, which will have to [be done], and then there is this whole thing about secrecy; about keeping things confidential. And that's anathema to us. Here's somebody who is keeping their stuff under lock and key; what does that say about us, in that [the newcomer] has access to everything we write, but we don't have access to the things [the newcomer] writes.'* (D)

All team members were expected to regularly attend meetings and give account of their actions; this professional did not do so. On occasions where the newcomer did attend, the contribution was perceived to be unhelpful, offering little advice on particular patients rather than joining in the planning process.

Where therapists adhered to a timetable of sessions and negotiated with each other, this professional declined to make appointments, preferring to see patients on an *ad hoc* basis. Where it was an expectation that people respected each other and patients, the newcomer was felt to show a disregard for other professionals and a negative attitude towards patients. Further, there was a perceived reluctance on the newcomer's part to reveal the basis of his clinical decisions, and how he intended to proceed with a programme of care. This upset and confused some patients, and fostered doubts in other team members about the extent of the newcomer's knowledge and skills.

In interview it was clear that the newcomer inhabited a different culture, where professional boundaries were rigid, and a high degree of distance from others had to be maintained. When asked what made for effective teamwork the professional responded that tight professional boundaries were all that was required. When asked whether communication was important, the reply was *'What do you mean?'*. Further explanation elicited the response *'Well talking, imparting information; I don't know'*.

This professional believed that operating in this fashion enabled the maintenance of control of the role so that elements were not lost to others. The behaviour was also in response to his perception that other team members played the team game while being more interested in personal advancement.

This professional's defensiveness and lack of trust was not endearing to other team members, indeed it seemed that there was little common ground between them. The director was the only person with whom this professional felt comfortable discussing issues, and when attending the occasional meeting, comments were channelled through the director, rather than to the appropriate professional. Eventually it was observed that other team members reciprocated in kind.

During the early months of the newcomer's being in post, team members offered the same formal integration procedure as they did to all new members. There were several *'uncomfortable'* meetings with the various professions, where they spoke about their roles and asked the newcomer about expectations of *'slotting in'*. The response was seen to be *'frosty'* in that the newcomer would not define ways of interacting with other team members, and declined to watch various groups working together. One therapist's frustration prompted her to say:

> *'It's kind of like you are pulling a dog that doesn't want to come. You are pulling at it's lead and it's like it's digging its paws in and saying "I'm not coming". I get the feeling with him that he's stuck in the position he's in. You could try and try and try but I'm not sure the will would be there.'* (OT)

The director was regularly informed of the non-integrative behaviour of the new professional, one of the main problems being seen as its impact on patients. The outcome of all disciplines' assessments were talked through with patients so that they knew what would be planned for them and why. In this way patients could understand their programmes of therapy, even if they did not always feel enthusiastic about interventions. The new professional was perceived to be inconsistent; either there was no feedback to patients, or feedback may have conflicted with that of the rest of the team:

> *'Our concern was that [the newcomer] was talking to patients and relatives, and probably giving them feedback from the assessments, but what [the newcomer] was saying didn't always tally with what our experiences had been. And we felt that the patients and the relatives might well be getting confused and mixed messages, and who should they believe? We felt it had cropped up because [the newcomer] hadn't been telling us the findings, and that the patients would often be very upset by what had been said and we would spend a lot of time of our session being debriefed.*

And you then were thinking "well have we gone wrong with our assessments, is there a right is there a wrong?".' (OT)

The director responded by calling a meeting with all heads of department and the newcomer in order to *'pin down'* the professional to attend certain meetings and operate in a similar fashion to other team members with regard to note-keeping and appointment making. The outcome of this meeting was an agreement for all relevant professionals to meet once a week to discuss assessments done by the newcomer. By the end of the study, two months after this meeting, only one meeting had occurred, three days before the researcher left the unit.

The effects of employing a professional so unlike others in the team was seen to have created *'a tidal wave'* in the unit. Team members were not only angry at this person's behaviour, but also, given their predilection for reflecting and evaluating practice, they began to ponder on the nature of their team interaction and how a non-team player could have been appointed to the post; a matter on which the director himself reflected:

'There was no consensus view about his employment; I did it. I'm the one who spent the money, and if it screws up then it would reflect on me ... that [the goodwill] will only run for a while. If we can't get it to work, then we'll have to think again.' (D)

This last section raises the issues of team cohesiveness and integration, which as suggested earlier, work well only if the incoming person shares the team's values and beliefs, or is prepared to change. The above comments by two therapists reflect the team's expectations clearly in that regard. This level of unity may have had its disadvantages, however, since it militated against containing non-conforming members within the group. This may have been counter-productive in terms of patient outcome since the non-team player may have provided tangential but effective ways of dealing with patients or other team members. In this case it seems unlikely, since the newcomer was not prepared to share ideas and opinions, with others disallowing them from building on this expertise and adding to their own, thereby providing more comprehensive programmes. However, it is a potential disadvantage which should be considered in terms of how people are prepared for teamwork.

One final role to be discussed is that of nursing, and the findings here echo much other research into rehabilitation nursing (e.g. Fokke, 1994; Johnson, 1995).

4.10.3 The jacks of all trades

There were widespread perceptions of a degree of dislocation between the therapy groups and the nursing group. This was spoken about mainly in terms of how it affected communication. It is important however, to reiterate the degree of closeness being discussed here. In all conversations about the nursing role there was always the proviso that *'it is so much better here than anywhere else I have ever worked'*. The dislocation between therapists and nurses only seemed to stand out because the therapy groups were felt to be so close.

The difficulty was perceived to relate to the lack of consistency of information-sharing and feedback, as the following, different quotes show. In the first a therapist was saying how she felt she *could* rely on the nurses to support her cueing strategies in their regular interaction with the patient:

'When we had that patient here who was disorientated; the way when they used to report back how he was behaving, most nurses would have been doing things automatically like "what's today's date, can you see the calendar", and things like that, they just do it.' (SLT)

In the second quote, another therapist was responding to a question about the frequency of poor communication in a more negative fashion:

'Yes sometimes, quite frequently unfortunately; and that's not just from my department. We might discuss something in the meeting and then it doesn't happen and you know you've got to go and reinforce it several times, which is difficult and no one likes to do it.' (SLT)

Therapists felt that part of the problem was the nurses' shift system, which meant they were unable to tell all nurses who may need to carry over a particular technique with a patient. As a result of needing to rely on others relaying the message, *'somewhere along the line'* communication broke down, inhibiting the development of a trusting relationship. This was despite there being a clear line of communication from the primary nurse to the others in his/her Team.

Therapists identified that time constraints and staff shortages may also cause communication problems, although, as the nurses identified, they had more time in this setting than many others. One therapist commented however, that different interpretation of needs may be to blame:

'Some nurses feed back better than others. To be honest I think they feel "what do you know, you are not here during the night, or during the evening, we are going to do it our way anyway".' (PT)

Although there were several organisational and geographical reasons why a communication deficit may have occurred, the following factors may have contributed to the perception of dislocation: *lack of role clarity, ambiguity of role, lack of professional support, perceived difference in status, the direction of flow of knowledge and educational disparity.* This section argues that these factors gave rise to feelings of *low value* among the nurses, and may have been more influential in creating the perceived difference in cohesion with this group, and, as a result, the communication gap.

It was clear that *perceptions of the nursing role* seemed to pose the most difficulties. The therapy groups wanted to feel the same type of cohesiveness with the nurses as they did amongst themselves, and had no doubts about the value of the nursing role:

'I think their role is absolutely essential in the rehab process and that they should be here [points to the middle of her drawing of the team], because clinically it is easy to do something in a session, but unless it is carried over it is absolutely pointless.' (OT)

Some nurses felt as if they were playing a supporting role in a therapist-led environment and simply *'part of the furniture'*:

'Nobody comes here because there are nurses, they come here because there are physios, OTs, SLTs.' (N)

4.10.3.1 Lack of role clarity

All therapists acknowledged the importance of the nursing role but had a similar view of its diversity and how that might pose difficulties in terms of role clarity:

'I think they have a very difficult role. They have to maintain the hygiene, the continence, the safe medical status of the patient, at the same time we are asking them to try and implement therapeutic aims out of therapy. They have a role to support the patients when they are not in therapy, a listening role if not a counselling role. They support the relatives, and it's always at weekends and evenings or in the middle of the night when patients become stressed, so I think they have an awful lot to cope with.' (PT)

'I think their job is very difficult, because it is so non-specific; they are doing everything aren't they? They are doing the swallowing work, they facilitate communication, they've got the medical role, in fact they are

carrying the medical role; they are the buffer between the medics and us, because we are saying "oh why haven't the medics done this?" to the nurses; they have a lot of contact with the carers, because again it is the hours and the weekends. I think the question "what is their specific role?" that's the difficulty I think, because it is non-specific.' (SLT)

Both quotes comment on the diversity of the nursing role, but do not acknowledge that nurses have a therapeutic input in their own right. The role was seen in sharp contrast to the therapy roles which were well-defined (although grey areas were observed between OTs and SLTs). As identified by the director and reflected by the therapists, these groups were confident of their professional practice partly as a result of working so closely with others in the team, but also because of the clear direction of their work.

For their part, however, some nurses felt as if the role could be seen as:

'Anything they can perceive it to be. Helper, or substitute therapist, waiter, slave, you name it the perception's there.' (N)

There was not consensus among the nurses regarding the degree of negativity of this perception. For example, one acknowledged the problem but spoke in a far more positive way about her contribution:

'I think its easy to devalue nurses, and nurses are very good at doing that anyway. Its a problem I think because we are Jack of all trades, and we tend to think of ourselves as master of none, without actually realising that we do have specific skills and training which make us unique individuals within the team as well.' (N)

However, the perspective of nurses as lacking a clearly-defined role *was* shared by the head nurse, who had given the researcher a journal article relating the lack of role clarity for nurses working in rehabilitation, and commented that *'we all feel the same as this, you could feel the frisson in the office when it came out'.*

4.10.3.2 Ambiguity of role definition-nurses or rehabilitation nurses?

In addition to the non-specificity of the role, the main aspect which the nurses themselves defined as nursing as opposed to therapy carry-over, was attending to *'medical care'*:

'The other side of the work is medical, and I don't think there's any doubt about that, we are the people who administer the medication, observing effects, taking BPs.' (N)

Some nurses felt that this role was limited in the rehabilitation setting by comparison with acute nursing, (although during the study there were several medical crises). The perception was acknowledged by others:

'In acute they have a role and they carry it out. I mean their esteem is affected by greater things like the hospital and pay and pressure and beds and other issues, but their general esteem in what they do is I think quite high.' (OT)

Indeed, as identified by the head nurse, rehabilitation demanded that nurses pursue a *'hands off'* approach in order to encourage patients to become more independent. One of the more disaffected nurses felt deskilled by this; perceiving that others' trust in terms of professional standing was undermined:

'Firstly the medical knowledge needs to be there, to the extent that people feel confident in your knowledge and your skills, your abilities, basically they have got to trust you, that is what your fellow professionals look to you for. It's a bit difficult here because you are out of the main stream of a

medical model of care, therefore you can't help but miss out on a lot of what is happening in terms of the application of knowledge in procedures etc. There's nothing like having to do a procedure to reinforce your knowledge base. It's difficult here because you don't do a lot of procedures.' (N)

It would seem that this nurse was still self-defined primarily as a *'nurse'*, and not a *'rehabilitation nurse'*. Conversation with other nurses and observational evidence suggest that this perception was widespread, although an exception was discovered. One nurse had taken a course on *'rehabilitation nursing'* and stated that she felt *'part of the therapy team'*. She had attended a conference for rehabilitation nurses and said she would have preferred the rest of the therapy team to have attended, as her identification was now more with them than with simply 'nurses'. This did not mean however, that she felt herself to be a therapist, but *'a cross between the two'*. This nurse's documentation also displayed a clear and analytical approach to patient problem identification. While the course may or may not have helped her define her role and use effective problem-solving techniques, her practice was noticeably confident.

4.10.3.3 Lack of professional support

Many team members commented on the way in which the trust seemed to provide limited professional support for the nursing group:

'But to be fair to them they are seen as an offshoot of the main nursing services. Their director hasn't even come once to see them. They have no feedback from the trust.' (GP)

Although along with other team members, the nurses respected and felt emotionally supported by the director, he was unable to give them professional support. All the other professional groups had their own supervisors who came as requested to advise, teach new techniques, or give information about new research findings which might be helpful. This was not apparently available for the nurses to the same extent. As a result, they were extremely frustrated, with one nurse commenting that the way in which the unit was ignored by the trust reflected their poor view of the nursing role in rehabilitation.

4.10.3.4 Perceptions of lesser status

The difficulty cited above was reflected by the nurses, and acknowledged by other team members. There was a sense in which the care aspect of the nurses' work was somehow of a lesser status than the work performed by the therapies:

'We are the ones who are supposed to get our hands dirty and they don't ... therapists, mainly OTs because it tends to be their patch, tend to do the washing and dressing assessment. But for some reason they only do the upper half of the body, so I think that speaks for itself really. There are certain aspects of care that are intimate or not very pleasant which are seen as the nurse's job to do.' (N)

One therapist acknowledged that the therapy groups operated with the nurses in a way which might reinforce such feelings:

'We kind of call on them to say "come and have a quick look at this transfer here" or "can you just go and get blah di blah out of the nurses' station so they can have a quick look at this"; and that's not how I work with the other therapists. When I work with them it's "let's plan a session" or "let's book in a whole hour together to look at that, and let's talk about it afterwards" ... Nursing is almost kind of like they are disposable, which is not nice.' (OT)

In addition to feelings of lesser status related to the nature or process of the work, there was also the perception of therapy prioritisation from patients and relatives. One member

of the team observed that in a therapy-led unit there would *'quite naturally be a hierarchy of expectations'* as far as patients and relatives were concerned, with *'wanting to walk'*, and *'wanting to talk'*, being considered most important. This was felt to be reflected in the perceived dominance of the therapies.

4.10.3.5 Direction of knowledge flow

A factor which may have reinforced the perception of secondary status among the nurses was the direction of knowledge flow. This does not mean that there was not a two-way flow of information and knowledge; nurses were frequently heard to give therapists medical advice and feed back details of patients' emotional state or social difficulties. It was the nature of *prescribed* knowledge flow that created the problem. The therapists assessed patients, drew up a plan of therapy and then, using the problem/goal orientation, their actions defined *team practice*, i.e. all team members were expected to help in carrying out those plans as and when appropriate. Since all therapists would draw up their own plans and have similar expectations of other therapists, any 'carry-over' they were required to do in their own sessions was not perceived as a problem; it was simply part of the therapy process.

The nurses also assessed patients and drew up plans of care and treatment. However, their plans only defined *nursing practice*, since the therapists did not take part in those aspects of care, a fact that was perceived by both therapists and nurses:

> *'And also when the problems are defined, when we are writing the problems in the team meetings, often the problems which are nursing related problems, are things like medication, which I wouldn't have anything to do with, they are kind of isolated problems.'* (OT)

In many ways the nurses' position could be identified with nurses' position in the medical model, administering and carrying out treatment on behalf of the medical team. Further to this, since the Bobath principles defined many carry-over techniques, the direction of *education* was also perceived to be from therapists to nurses. All therapists spoke about *'getting the nurses together to talk to them about ...'*.

> *'So there's a visual aid as well for the nurses, because obviously the transfers that they've been used to are very different to the transfers and techniques that we are taught in physio college, and it's in a unit like this where we are able to teach a lot more.'* (PT)

This was tempered with the insight that they needed to be diplomatic in doing this:

> *'Although I have [got nurses together] many times, [that] is get together in a patient's room with a group of the nurses and actually get them to do it as well. But I try very hard not to make it seem that I am testing whether they are doing it right or not.'* (PT)

This type of interaction was not observed to have been reciprocated by the nurses, and indeed was not identified as a common phenomenon because of the emphasis of the unit (but also shows the limitation of what the therapist quoted below felt a nurse might be able to teach others):

> *'I'm sure they would do specific teaching sessions on certain illnesses if we wanted but it doesn't tend to crop up here because the patients have to be medically stable to be here. From that aspect I can't see that, that role would be needed.'* (PT)

Therapists were enthusiastic to learn from each other, but this was accepted in the knowledge that they too could teach others. The nurses did not seem to feel they had the same teaching role, simply because they did not think the therapists would be interested in hearing about continence or skin integrity. Thus the knowledge flow remained one-way to a large extent.

4.10.3.6 Educational disparity

Two issues related to educational parity:

- the large number of experienced and inexperienced but *untrained* staff (i.e. nursing assistants) in the unit
- the difference in *problem identification and approach to problem solving* of the nurses.

The first factor related to the difficulties experienced by some therapists in obtaining feedback and to instigating plans despite having spoken at length with the nurses involved. It seemed to suggest that for some nursing assistants, following instructions could be confounded by lack of knowledge base:

> *'But knowledge base does make a difference. Because of my knowledge base I know that if he doesn't get positioned in that position then this is going to happen. But without that knowledge base it may seem really pernickety, you know "why does he have to have his arm there". I can say why I want them to do it, but if they don't have the understanding, then they might not think it is that important. But then maybe they could come to me and say why, and I do think that some of them find it harder to come to us than we find it to go to them. And I think that is training.'* (PT)

Unless the basis of the principles used by the therapists were fully understood by all nurses, the chances of them giving the optimum weight to carrying out the programme in the prescribed manner would be inhibited.

The second factor became evident at two training sessions where the collaborative note system was discussed. There was a long discussion about the difficulties of problem definition. This applied to all team members, where wording a problem in order to define the path of care or therapy accurately, was difficult. In order to address this a case scenario for each discipline was worked through.

During these case discussions it was observed that the nurses approached problem definition differently. This related to the specificity of problem definition and its antecedents. For example, one nurse described how, if she defined a problem as incontinence, she would put as the antecedents *'?brain injury or ?infection'* then investigate whether there was an infection before assessing anything else. The therapists said that if they put *'brain injury'* in the antecedents box, that would cover all problems in the unit. By the same token if they were to be as global as nurses in problem definition they might simply put *'unable to walk'*. One therapist said *'well how about defining the problem more specifically such as "inability to make known her wish to use the toilet", and then that would make your antecedents "poor initiation", or it might be that her memory has been shot and she wouldn't remember where the loo is'*.

The nurse did not pursue this point and the debate moved on, but an interesting point had been made. It seemed that some nurses had a different way of analysing problems. This may have related to the difference in their training approaches given that few had benefited from training using problem-solving models. Since one nurse raised the issue with the researcher, it was felt that highlighting the analytical discrepancy may only have reinforced some nurses' more negative feelings about their professional standing.

4.10.3.7 Perceptions of low esteem

These negative role perceptions seemed to be related to feelings of low confidence and self-esteem among several nurses:

> *'But it's because we are carrying on their therapies whereas they don't actually want to know what nurses do because it's not pleasant is it ... and that is quite hard to accept sometimes, especially when you are coming from a low position, and nursing is still here.'* (N)

Others corroborated this perception, for example:

'And I don't mean to sound arrogant or proud, but I feel that it's a professional esteem issue.' (OT)

'I think sometimes the nursing team just feels unloved and unwanted, and then I think the team tends to break down, or not exactly break down but you have a blip.' (PT)

4.10.3.8 Team attempts at dealing with the issue

The team had obviously at some stage discussed the issue of nurses' self-esteem at length since there was seen to have been a concerted effort to improve the situation. However, one therapist spoke about her ambivalent feelings on the subject:

'And we're often told, "oh don't put the nurses under pressure, don't ask them to do this, don't ask them to do that because it's not fair". We always seem to have to accommodate to their morale, which I find a bit much really.' (SLT)

This sense of having to accommodate the nurses rather than their being treated as equal partners in the team, was expressed by two other therapists who spoke about the problem of having always to use *'diplomacy'* with the nurses and how it *'frustrated'* them.

The director had spoken with the nursing group about ways to enhance their role and, with the head nurse, developed a plan to extend their counselling role. By this he did not mean that nurses should train as counsellors, but that they should use their listening skills in a more structured way, encouraging patients to talk about issues (such as altered body image, or sexuality) rather than it happening by chance. The aim had been to make the job more inclusive and holistic.

In the 18 months since the plan had been agreed, there seemed to have been no moves towards implementation. It had been reported that the nurses did not want to take on what was seen as an extra role (without extra pay). Their reluctance was also related to the nurses' ambivalence about managing patients' emotions in this more structured way:

'I mean counselling is usually more time managed, but this isn't, because the time we are talking about may be many years. Some people may never come to that. I think the most important quality of the interaction is to be honest but to be kind, and that is not counselling. So we don't try and hit people over the head and say "you must understand this is how things are", we just try to help people.' (N)

Some felt that it would not be appropriate to take on this role without a great deal of extra training, since:

'The difficulties with the psychology side is that people don't know much about it, it's seen as akin to alchemy or magic or something. There are people who can to do it, but they are psychologists.' (N)

The outcome of this attempt to improve the nurses' image seemed to have backfired, with some nurses feeling they were being asked to do something they did not want to do, nor felt prepared to do.

4.10.3.9 And thus the communication gap?

The evidence above identified several negative perceptions of the nursing role and the way in which these seemed to impact on nurses' professional perception. Within the nursing group there was a general sense of having to take on many aspects of the therapy culture in order to maintain their position. For example, the Bobath principles were expected to be

continued by all team members, uniforms were therapy-identified, and the collaborative notes were therapy-led. This last factor reinforced the nurses' feelings of being 'second-best', since they had wanted to retain their own note system.

> *'The notes were foisted on us we didn't have any say in it, and now what we have is a hotch potch of notes, some in the nursing office and some in the notes room.'* (N)

This perception was echoed by several nurses but did not tie in with what was said by either the director and the therapy groups in terms of the instigation process followed. The feelings engendered by the perception of having been 'taken over' resulted in an inconsistent pattern of entries in the collaborative notes. Two nurses wrote copiously, not only under identified nursing problems, but also under jointly defined problems. Others wrote most information in the nursing documentation and the 'handover' book, both of which were kept in the nursing office. Several nurses said that *'we hardly ever look in the collaborative notes'*.

It is possible that the tokenism towards collaborative notes by some nurses further defined the separation between the groups; historically it had certainly caused frustration among therapists who had made long entries in the notes requesting support or feedback without acknowledgement from some nurses. This had led to the introduction of the handover book, and information flyers which were posted in patients' rooms and the nurses' office.

The communication gap may have been reinforced by a dislike of having to go to therapists for information and knowledge which the nurses felt was not reciprocated, thereby creating assumptions of how and why plans needed to be pursued in a certain way. Finally it is possible that some nursing assistants simply did not understand the relevance or importance of certain procedures and therefore did not ensure their continuity.

The factor which seemed to be missing in the situation was nurses having a voice about their role and how they were prepared to develop it themselves. Instead there was an ambience of resentful deference, which, while *not* universal among the nurses, was strong enough to make itself felt. There was a sense of some nurses behaving in a reactive rather than proactive manner, in a *non problem-solving* fashion. The way forward for this group would seem to lie in the development of a more analytical framework for their practice, that would help them to define themselves as 'rehabilitation nurses'.

4.11 Conclusion

A number of significant features of this case study contribute to staff's ability to work together; these are analysed in Chapter 5. The analysis reflects the influence of the organisation, the group and the individuals making up the team and provides a framework for the discussion of the other case studies.

Key points

- Geographical proximity, stability and predictability have a supportive effect on collaborative practices.
- Managerial collaboration facilitates multiprofessional teamworking.
- Designation of professionals to the specialism, and working with the same patient group support collaborative practices.
- Collaborative practices enabled the achievement of comprehensive and multiperspective communication and multilayered role understanding.
- Team skills and knowledge developed through role flexible working.
- Collaborative practices and the development of a learning environment benefited:
  - patients: continuity, consistency, appropriate referrals, reduction of ambiguity, holistic information, problem solving
  - team members: professional development through exchange of knowledge and skills.
- These collaborative practices suggested specific learning implications relevant to students.

5.1 Introduction

Evidence from the case study presented in Chapter 4 gives an example of a group of professionals who had, despite areas of tension, developed a highly collaborative level of multiprofessional practice which was termed 'integrated working'. They had recognised the need for, and developed to a large extent, a shared philosophy of care and a system of joint working practices. These promoted in-depth understanding of each other's roles, and a facilitative communication system. With the help of a facilitative leader, a culture had developed in which professionals shared their skills and knowledge, creating a fund of 'team knowledge and skills'. For the patients in their care this approach had readily identified benefits which are discussed later in this chapter.

This group felt part of a multiprofessional team; a phrase much used to cover a wide variety of multiprofessional groupings which may or not be involved in the activity 'teamwork'. Some professionals working in a multiprofessional context are specifically designated as a team, as in diabetes or community mental health teams. Some feel that working together can be described as 'multiprofessional teamwork'. However, the term 'team' has become used to describe almost all multiprofessional groupings, whether or not they practise 'multiprofessional teamwork'.

This chapter and Chapters 6 and 7 demonstrate that some multiprofessional groups work more closely than others. This chapter discusses the group in the rehabilitation unit. They felt that their close, integrated form of working provided effective outcomes for patients. Chapter 6 explores other groups, some of whom worked in a more fragmented fashion. Although individual professionals may have identified that their work with patients was effective, this was not part of a 'team' focus. Chapter 7 explores a 'core and periphery' type of working in which a subset of a multiprofessional group, the 'core', had developed more collaborative working, leaving other professionals in a peripheral position.

The research team does not pretend that the three forms of multiprofessional working identified from the case studies were exhaustive, simply that this was how various groups saw their practice, and the reasons why it had developed in that way. Each chapter addresses three levels of analysis to explore the issues which helped or hindered these groups to work together:

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- organisational aspects and how they impact on multiprofessional working
- the effects of group process in terms of how professionals relate to each other, and how their roles are perceived
- individual perceptions of 'multiprofessional teamwork' and how readily they marry with each other.

In each of these sections some learning implications for students coming into health care professions are identified.

The final part of this chapter identifies a number of benefits to patients which integrated working seemed to provide. It is not suggested that the collaborative practices in this case study are the only way to operate collaboratively and achieve those benefits; some teams would not have the time or accessibility. However, it suggests that collaborative working demands ongoing discussion and agreement about a system that is appropriate for a particular team, and a shared understanding of what a team wants to achieve and how to achieve it. The benefits to patients that this team's working provided, *did not* apply to the same extent in the other case studies, but indicate how patient care could benefit from a multiprofessional teamwork approach.

5.2 How the organisational environment affected multiprofessional working

The impact of the organisational context on professionals working together has many ramifications for the possibilities of developing team practice. It has been argued that without a degree of congruence between the various levels – from senior management to those working 'at the coal face', and supportive organisational structures, a collaborative approach will be undermined (Nadler and Tushman, 1980), or even be impossible.

From the rehabilitation team case study, six organisational factors were identified which supported opportunities to develop integrated practice. They could be subsumed under the broader factor of cohesion, since in combination they provided a cohesive context within which the team operated, and included:

- working close together
- having a stable environment
- being able to predict what happens
- being a specialist team
- having supportive management structures
- having matching organisational policies.

5.2.1 Working close together

Team members were based together in a discrete unit. This proximity provided the opportunity to develop comprehensive communication and in-depth role understanding considered important aspects of teamwork (Abramson, 1990; Furnell et al., 1997). It also allowed personal relationships to develop which could underpin the motivation to communicate and understand each other's work.

In terms of communication, proximity allowed professionals to engage in *ad hoc* information sharing and discussion. Although each profession had an office where they held monoprofessional meetings, in general there was open access to all rooms. Team members, for example, would frequently congregate in the nurses' station or therapy area to discuss a particular issue. Proximity also allowed professionals to allocate time for numerous structured meetings without needing to travel, making maximum use of time.

In terms of role understanding, proximity enabled team members to observe each other's practice, since much work with patients was carried out within a common area. Initially this was a double-edged sword for new professionals since they were 'on display', which could have been interpreted as a negative aspect of the environment. However, the team's supportive culture, and the proximity and thus openness of practice provided a foundation on which team practice could develop, through understanding what each professional contributed to patient care.

Finally, because the unit had a communal space where all professionals could take breaks, they could develop social relationships. This communal area also gave people a chance to discuss aspects of interactions between themselves and patients, among team members, or between the team and the rest of the trust which may have been considered 'politically incorrect'. In short, they could 'let off steam', and this opportunity was perceived to help cement working relationships.

The geographical proximity in this unit did not guarantee development of a professional communication system, understanding of each other's roles, and close personal and professional relationships. It simply gave opportunities which team members could take advantage of or not. The example of the new member who did not take the opportunities showed clearly that proximity was only part of the picture.

5.2.2 Having a stable environment

The rehabilitation unit provided a stable environment where both patients and staff remained for long periods. Stability of practice allows for two main developments:

- the building of relationships between team members, and between professionals and patients
- the growth of expertise about the patient group.

In terms of relationships between professionals, stability allowed team members to develop an understanding of each other's strengths and weaknesses, and how to manage those within the team context. Many members clearly understood each other's role, which will be explored further in Section 5.3. However, without a stable environment in which various aspects of other team members' practice is exposed, how can professionals understand how their colleagues cope with their role within the team? Where there is stability, a team member can gauge another's ability to contribute effectively. Where that professional is seen to operate in ways which may be directly detrimental to the patient, or effective patient care is compromised, team members can develop ways of managing that deficit.

Stability also allowed individual professionals and the whole team to develop a relationship with patients. In many situations individual practitioners have ongoing relationships with individual clients or patients, however, other professionals caring for the patient will change. The long-term employment of staff within this unit allowed a team relationship to develop with the patients, who were rarely in the unit for less than six months. Through the regular and repeated joint approaches to care, patients could see professionals interacting and determine how those interactions provided a congruent pattern of care. They could therefore develop trust in the team, rather than an individual, giving them the confidence to express their own feelings about their rehabilitation.

The stable environment also enabled team members to deepen and extend their skills and knowledge in the particular field of rehabilitation. Given the team's predilection for reflection and evaluation, stability enabled them to evolve and develop processes of care and therapy, either from attending relevant programmes of education and conferences, or from observation of other rehabilitation teams.

There is a caveat to this organisational aspect: in environments where challenges to the care and therapeutic processes might not be identified so readily, stability may lead to

stagnation. Because this team appeared to maintain a system of reflective process this was not considered to be so likely.

5.2.3 Being able to predict what happens

The unit had a high degree of predictability, which applied equally to team members and patients. Patients were admitted using a negotiated process, allowing team members to plan their work to some extent. Negotiated timetabling enabled members to predict each other's movements on a day-to-day basis, reinforcing their ability to determine when they would be most likely to catch another member to pass on information or discuss relevant incidents. It also allowed each team member to prepare patients for the next aspect of therapy or care. With a predictable context, continuity of care could be maintained to a high degree, as it was easier to piece together various team member's contributions.

Predictability also allowed patients to understand when and where they would be treated, since each had a tailor-made timetable. This enabled them to arrange activities in the knowledge that these would not be overridden by other priorities. Patients could also predict who would care for them, again encouraging the development of trusting relationships between professional and patient.

5.2.4 Being a specialist team

All staff (except junior PTs) were permanently assigned to that specialist unit. This meant there was no diffusion of their skills and knowledge through the need to perform a wide variety of aspects of their professional role to a diverse patient group. For example, the OTs could focus on a particular aspect of therapy, developing in-depth knowledge and skills related to the identification and management of cognitive deficits. The exception to this was the nurses, some of whom felt that their skills were diminished by working within the rehabilitation environment for reasons identified in Section 5.3.

Team members also had no other call on their time; their focus was entirely on the team and its patients. Apart from the practical advantage which the designation of professionals facilitates, this organisation seems important in terms of team belonging. A sense of allegiance to a group is bound up with members identifying with its particular focus (Brown, 1988). Further, the specific designation indicated the professional's interest in this field, and potential motivation towards the focus of care.

5.2.5 Having supportive management structures

Related to the issue of designation was that of professional versus team management, and through the latter, team allegiance. This had a cultural and a practical component. Although all professional groups had separate external senior line management, within the unit, each had a manager who functioned as a team member. These managers, in turn, were part of a collaborative management structure, led by a non-medical director. In effect there was parity of status at this level, encouraging equality of professional input. Although the director had the final say in decisions, his non-clinical position allowed appropriate weight to be given to other management team members' input. This multiprofessional structure in which each manager also had a clinical aspect to their role, made it possible to promote team members' primary allegiance to be to the team rather than their own professional hierarchy.

Regular meetings of this managerial layer enabled ideas from the professional groups to be raised and discussed. It was also possible for decisions relating to team practice to be negotiated and fed back to other team members. Since the unit was largely autonomous, the director was then able to action any agreements. This enabled the team to develop, in a multiprofessional manner, strategies for a number of aspects of the unit, both clinical and administrative, which were then widely accepted by other members, thus reinforcing their allegiance to the multiprofessional group.

5.2.6 Having matching organisational policies

The team worked in an environment where the same organisational policies held true for all staff, with no confusions across trusts or agencies regarding guidelines for professional practice. Furthermore, the policy of bed management (where patients are placed where there is a bed rather than in their specialist area) did not apply to this unit, protecting it from the encroachment of its specialism.

As part of their debating process, this team also discussed relevant policies in terms of what they meant for team practice. The director was aware of the need for professionals to be involved in many aspects of the organisation, such as budgetary and resource concerns, in order to understand potentially disruptive decisions. It also allowed team members to suggest ways to minimise the effects of these policies.

The development of separate community and acute sector trusts and the bringing together of local social services with health agents, has raised the potential for conflict where these bodies need to work together across that interface. Unless close working relationships evolve, and unless those most intimately involved with the outcomes of those policies, are included in the discussion process, there is a high potential for mismatched policy development (Øvretveit, 1990).

These organisational aspects have much to tell us about the kinds of structures which help to promote multiprofessional communication, role understanding, the development of a shared vision of teamworking, and a sense of belonging to the team. However, several of the aspects discussed above would not be available in many contexts within the NHS. Those who can take advantage of such opportunities should perhaps consider themselves privileged to practice in such a supportive environment.

5.2.7 Learning implications

- Students should understand the context within which they operate in teams: the organisation, its policies, structures and processes, and how these might impact on the team.
- Best practice in terms of teamwork may not be possible in all environments. For example, stability and predictability may need to be present to allow teamwork to develop, as may the team and its members having specific designation.

5.3 What it meant to be a team member

The belief that one could bring together a multiprofessional group of people and simply expect them to provide effective teamwork seems somewhat naïve. They would probably have different status and power assigned within the organisation, and be socialised into different professional cultures. These differences have the potential to create tensions; for example, the way in which newcomers are incorporated, the type of leadership, the role contribution of various members, and the beliefs and values within the team, would be affected by issues of status, power and culture. These are important issues, and suggest that the way in which a multiprofessional team functions requires attention and effort from all concerned.

The rehabilitation team case study identified some factors which helped to promote this level of collaborative working, for example a shared vision, understanding each other's roles, and effective communication. In order to reach these goals, professionals would need to address and develop a shared understanding of the kind of team practice required. The term 'shared' was used frequently in Chapter 4 to define the team's approach to work: all members participated in the development of specific practices, policies or a philosophy of care and were prepared to practice accordingly. However, it does not necessarily describe all individuals' thinking about these issues at all times.

Sharing did however, imply that interpersonal interaction was an important part of the team's daily activity. In order to provide a comprehensive picture of this team's working an understanding of the underpinnings of this interaction within a group process context is needed. What group factors helped to create integrative working, and why in two cases (the nurses and the new team member) were there discrepancies?

This section examines the importance of similar beliefs and values for this team, the effect of its leadership on its working processes, the team's attention to role contribution, and the integration of new members.

5.3.1 Beliefs and values of the team

To develop an effective means of multiprofessional working, professionals need to address not only their own practice, but also the interactions of the multiprofessional group in which they work. For example, the rehabilitation team had developed a highly-structured system of joint working practices including dedicated times for clinical discussion, joint note-keeping, and joint clinical procedures such as assessment, problem identification, monitoring, therapeutic intervention and evaluation. They saw this as an integrated approach to multiprofessional teamwork. However, all these systems were based on a number of expectations, within which the values and beliefs of the team were made explicit. In effect, many team members behaved in a way which was congruent with their espoused philosophy of teamworking. This outward display of team values such as openness, directness, reflection, and respect, reinforced the team's culture to existing members, and to new members of the team.

One aspect of the team's working week, the regular clinical case discussion seemed to be a useful vehicle for ensuring effective communication, however it was simply the bare bones on which the team had to provide the flesh, i.e. commitment to the process. Implicit in that process was the fact that all professionals attended and contributed information regarding a particular patient, and that time was made to discuss that case. Challenge to the *status quo* was considered appropriate; both on a specific clinical level, and in terms of more general aspects of practice. These expectations implied that each professional's contribution was worth hearing, exploring and acting on if agreed. The team not only attended to the primary reason for the meeting, communication on specific patients, but also to team dynamics, ensuring parity of input, learning from each other, and responding to each other's input. All these factors were felt to support the motivation to communicate.

The way in which this team functioned on a day-to-day basis thus had two components:

- providing effective patient therapy and care
- maintaining the team as an entity.

5.3.2 How the leader influenced the team

The evolution and continuity of the team's culture was largely acknowledged to be a function of the way in which the director and heads of the professional groups promoted this and acted as role models. Responses to an approach such as multiprofessional teamwork, when proposed by managers, has been described as 'lip service' (Poulton and West, 1993), and was voiced by participants in the other case studies. However, the leadership in this team was congruent with the team philosophy; several had previous experience of teamworking, providing them with templates of 'how to be a team member' which largely matched. The director also had a clear understanding of group process. Having helped to establish the structure and process of the team, the leaders of the professional groups and the director ensured that other members developed a similar way of being. In particular the director recognised and put into practice, strategies for encouraging openness in difficult circumstances, and provided practical and emotional support to help resolve problems. These elements combined to ensure that the culture was maintained.

In addition to providing an appropriate role model, the director encouraged a democratic team process. Although he was aware that he could have the final say in decision-making, he understood that many decisions had to be owned by the team in order to facilitate establishment of actions. Indeed, since he had no clinical skills, he could not have acted alone. Many of his comments showed the high esteem in which he held other team members, which was evident in the way in which he listened to and acted on their ideas and information. The director was also esteemed by the team. He had a high level of credibility and was trusted to support and promote the team. Leadership theory (Schein, 1985) suggests that support for leadership must be earned; where it is imposed, there is the potential for subversive or defensive behaviour, as is seen in later chapters.

This team, by its own acknowledgement was not 'perfect' however. The perceived dislocation of the nursing group caused concern. This partly related to structural issues and the resultant inconsistency of care, but also the nurse leader and some senior nurses did not seem wholly convinced of the integrative approach. This leader was considered an excellent nurse, and encouraged her group to broaden their skills and knowledge. In this way she was seen as a good nursing role model, not a team player. This degree of separation from the rest of the team was related to difference in role confidence, but it was disheartening for other members.

5.3.3 Knowing how the professional roles contribute to the team

Implicit in the concept of a multiprofessional team is the fact that each profession has its own specific contribution. Other research has shown (Iles and Auluck, 1990; Gibbon, 1992; Field and West, 1995) that in order to achieve effective teamwork, not only do individual professional groups need a clear understanding of their own role in the team, but also a well-defined appreciation of other member's roles and contribution to patient care. A final aspect of this understanding is where the roles meet; that is, do team members have a clear idea of how the boundaries of the roles engage.

Understanding one's own role was an important ingredient in the success of this team. Those with a high level of role clarity were confident in their contribution to the team. This confidence ensured that negotiations related to tackling specific aspects of patient care or therapy did not dissolve into debates about whose responsibility a particular action was. It also allowed members to identify areas which could be shared. In effect they had an understanding of role which presumed a specific core of knowledge and skills, and a periphery which could be pooled as a team role.

The nurses did not share this level of role clarity, and were less confident about the value of their contribution. A major problem was the contrast between the very specific input of the therapy professionals in the rehabilitation process, and the rather diffuse role which the nurses felt that they had. Nurses have been likened to the 'glue' which binds the other contributions, an all-encompassing role which has greater continuity than others (Johnson, 1995); the nurses were ambivalent about this definition. They could see its benefits to the patient, but many could not see its value to themselves.

A second aspect of role understanding is knowledge of other's role in the team. Team members need to understand what another role comprises, its tasks, whether any of those tasks interlink with one's own, and if so, how. This demands knowledge of how a role is accomplished. It can be viewed in two ways: the meaning of that role on a day-to-day basis, the constraints of time and resources; and the patterns and timing of specific actions. Team members then need to understand how those actions fit with their own.

Underpinning the *how* of a role, and of equal importance to other team members, is the *why*; why a professional is considering a particular intervention. This understanding of another perspective on patient care allows each member to reflect on the rationale for their own action, and potentially enables the development of a team perspective which incorporates the different approaches. This bringing together of different perspectives was seen in the tension

between the functional versus the Bobath approach to mobility, where the therapy and nursing perspectives were to some extent at odds. Some consensus had been reached, yet there was a sense that the nursing group was not always convinced of the applicability of the Bobath approach. Potentially both groups could learn from each other and modify the approach.

Through joint working practices and extensive communication forums, many team members had developed an understanding of each other's role on all these levels. Their roles were continually demonstrated and discussed, providing the third aspect of role understanding, the means for extending and interweaving roles, for example where the SLTs and the OTs found a common area related to memory. This team had to a large extent been prepared to make permeable the peripheries of their roles and therefore created team roles where many members could provide continuity in each other's absence, and an enhanced approach through the use of borrowed skills – for example where the PT used SLT cueing strategies.

5.3.4 Becoming a team member

Two aspects need to be considered in terms of integrating new team members:

- How does the new member demonstrate their willingness and suitability to be part of the group?
- What strategies does the team use which support the process?

Because of this team's firm beliefs that members need to be not only accomplished in their own role, but also prepared to be good team players, the route to team membership was clearly defined. New members needed to fit in with a number of expectations, in addition to providing the professional skills and knowledge that the role demanded. They had to be willing to expose their practice to a high degree – which some had found daunting in their early days, to communicate in a way which gave the maximum information and exploration of incidents and events without eclipsing others' input, and prepared to share aspects of their skills and knowledge.

For the existing team members, there were two aspects to the integration process: selection, followed by inclusion strategies. First, the director (and relevant professional leader) attempted to ensure continuity of the team culture through the selection of professionals who demonstrated willingness to be a team player. It was made explicit that this was of equal importance as their professional skills and knowledge (the newcomer in Chapter 4 was a singular example of where this did not seem to apply, and was seen to have related to the rarity of that profession). Because of the management rather than clinical role of the director, and the joint management approach, it was possible to pursue this course of action. In many teams, not only may the belief system be less than collaborative, but the process of bringing in new members may be achieved only on a monoprofessional basis.

Second, existing team members encouraged communication of the new member's ideas and experiences and facilitated the demonstration of skills and knowledge, from an early point in the integration process. They were also prepared to act on suggestions from new members if this was seen to promote more effective teamworking. In short, they behaved as if the new professional was an established member of the team. A final aspect of this process was the assumption of new members' inclusion in the team's social life.

During the case study the integration of several new members was observed. One new member did not achieve membership status during the study. This professional was unwilling to fit in, and hindered all efforts on the part of the team to include him. Despite continuing in the attempt, existing members became increasingly disillusioned, and finally wary of the professional's suitability.

Where multiprofessional groups have a less well defined sense of 'teamness', those who express their contribution in a different way may well be contained more readily. However, this professional's different approach to the collaborative working practised in the unit showed

clearly how individual perceptions of what it is to be a member of a multiprofessional group, can influence the way the team functions. This individual level of impact on multiprofessional teamwork forms Section 5.4.

5.3.5 Learning implications

- The benefits of developing a team culture which promotes accessibility to professional skills and knowledge within the team should be recognised. There was an awareness of the way in which multiprofessional working could enhance their core professional skills and knowledge through in-depth interaction with other professionals, and subsequent reflection on their own practice.
- The benefits to the team and patients of a culture which encourages a high level of collaborative working should be recognised. The way in which joint practices such as joint planning and evaluation, working in tandem with other professionals, and sharing notes can provide the following:
  1. a wider understanding of the patient's problems through multiple perspectives
  2. a sharpening of each professional's understanding of the patient's problem and their contribution to its solution
  3. continuity and consistency of service delivery
  4. a reduction in ambiguity for patients/clients, and reinforcing the content of the message
  5. the appropriateness and accurate timing of referrals.
- Developing and agreeing a shared direction for practice is important to team culture. Members need to be aware of the concept of shared direction and its benefits, and to understand that this needs to be developed through protected, regular time for reflection and discussion.
- Effective communication must be built from a foundation of informal social meeting and talking, opportunities for professional communication, and formal structured communication such as regular meetings. The different levels of communication and the importance of each should be recognised.
- The power of inclusion processes with newcomers should be understood in relation to group acceptance and incorporation. These processes may be facilitated by seeking those who are most approachable, and by professionals adopting an approach which is open to newcomers' ideas and actively promotes their incorporation into practice.
- The undermining effect on team cohesion created by perceptions of: lack of role clarity, lack of reciprocity of knowledge sharing, and lack of role value should be recognised and the core skills and knowledge which define a profession understood, to develop comfort with uncertainty in peripheral aspects of professional roles.

5.4 The individual's influence on multiprofessional working

While the organisational context and aspects of group process impinged on the ability of the rehabilitation team to work together effectively, the way in which individual professionals interpreted the concept of multiprofessional teamwork also had a major influence on team function. Within this team there were two areas of mismatch of interpretation; one between the majority of the team and a newcomer, and a second between the majority of the team and some nurses. In the first example three distinct components can be identified:

- a mismatch of team awareness

- a mismatch of role expectations
- a mismatch of communication expectations.

5.4.1 Mismatch of team awareness

Many members of this team believed that in teams people operate together to make decisions and define actions to be taken with a particular patient. They understood that unless decisions were made as a team, with the development of structures, processes and strategies which supported that process, patient care and therapy could be compromised. In effect members were motivated to support an integrative approach to multiprofessional working. The development and subsequent participation in joint working practices further reinforced and perpetuated these beliefs for those already in post and to those who later joined the team.

In addition to having a high level of motivation towards this concept of teamworking, many in the team recognised that attention should be given to individual and team concerns as well as those directly related to patient care. This dual approach to the team's primary tasks and its internal needs has been identified as fundamental in the evolution of effective teamwork (Schein, 1985). Both aspects of teamwork demanded effort from individuals, and members needed to believe that this was the best way to provide effective care.

The new member had no such belief this type of multiprofessional teamwork was an important aspect of day-to-day practice, and seemed to perceive more collaborative working as a threat. Furthermore, the purpose of working in such a cohesive fashion was not recognised as being of value to patients. Because of this lack of recognition of the need for teamwork, this professional made his own rules in terms of how he operated within the system of note-keeping, patient appointments, joint working, and attendance at meetings, making it difficult for others to predict when, how and why patient interventions would be taken. In effect his different belief system culminated in two methods of operating which were almost wholly at odds with each other.

5.4.2 Mismatch of role expectations

The existing team members and the newcomer also had different beliefs about the boundaries of the various roles in the team, what was valuable to understand about another's input, and what was valuable to learn from others.

Many team members believed that an in-depth role understanding was required for effective multiprofessional working in order to develop an understanding of what another professional did, and what that role meant in practice. Further it was important to develop a knowledge of the rationale behind what another professional was doing, and to gain insight into the nature of the boundaries between the roles and how they could best overlap for the benefit of the patient. Team members felt that the only way to attain this knowledge was through watching other roles in action.

Implicit in this level of role understanding was the idea that great value was attached to the development of a comprehensive picture of the skills and knowledge base with which another professional operated. In this way each professional could teach and learn from others, knowledge and skills seen to be more peripheral to each role. Through this process an area of team knowledge and skills would develop to be used to enhance patient care.

In terms of role understanding, the newcomer was seen to have a limited interest in, and understanding of, others' roles, and considered this level of understanding appropriate in order to function with other professional groups. While role clarity has been identified as having fundamental importance to professional esteem and effective team function, this professional's strong sense of role boundaries implied that no encroachment would be entertained. It left no room for negotiation, ensuring that he would be free to manage his own work without recourse to others.

This difference in perception about role seemed to relate to the way in which this professional valued others' contribution to patient care. Value appeared to be assigned in relation to a traditional hierarchy, with the newcomer's profession holding a high status. Learning from others was not seen to be part of the process of work, the implication being that there was nothing of value to learn from those of 'lower status'.

5.4.3 Mismatch of communication

Many existing team members perceived the need to engage in a rich, detailed level of communication related to the focus of care (the patient), concerns of individuals within the team, and the development of team knowledge and skills. It was seen as vital to give time to discussion and debate, both informally and within regular forums, in which all domains would be valued in assembling a complete picture of the patient's progress. The team looked at not only the physical, but also the psychological state and how that might be impacting on the patient's physical improvement. The patient's social context would influence the psychological state, so this would also be regularly discussed. Team members spoke about how beneficial it was to gain these multiple insights as it perhaps persuaded them to use a certain approach, or change the path of action they had planned to take.

It was accepted that each professional may need to discuss their professional, and indeed personal, concerns in relation to patient care. Team members felt able to discuss their feelings of inadequacy, dislike, and despair, in the knowledge that their audience would be receptive and supportive. This willingness to listen to others was not seen to be abused during the study – individuals were not observed to overindulge their feelings. By the same token, issues of concern related to other professional's practice were not raised in this setting either.

The nature of this communication could be identified as far more risky than that related specifically to patient progress. It would require a high level of personal and professional trust that others in the team would not only listen and support, but also reciprocate. In terms of group process theory (Brown, 1988) it would indicate high levels of cohesiveness, which in turn has been linked to effectiveness (although this may follow a curve, with excessive cohesiveness being counterproductive).

Finally, as part of the need to understand and learn about others' roles, communication was seen to encompass learning from and teaching each other, both in terms of formal teaching, and in *ad hoc* exploration of issues as situations presented.

The newcomer was unwilling to communicate in any of these three areas. He did not regularly attend forums where clinical or administrative matters were dealt with, nor contribute on the same level as others if he did attend. Discussion and debate in this arena did not seem to be considered appropriate; he simply gave and received information as requested. Brevity of communication was valued, with the implication that this allowed the professional to continue his own work. However, brevity was seen to create ambiguity on three counts. First, this professional's choice not to communicate closely with others impeded development of the wider picture of the patient, as others were prevented from having full access to the newcomer's assessments, decisions and actions. Second, people were unable to share the newcomer's professional or personal concerns, reinforcing the insular position he seemed to prefer. Third, the lack of explanation of any aspect of this professional's day-to-day practice was interpreted negatively by other team members. His high level of secrecy raised doubts about his competence.

The mismatch of the three factors described above led to conflict and resentment. Holding different conceptualisations of multiprofessional teamwork led to deleterious outcomes in terms of both professional interaction and, apparently, patient care. From an analysis of the differences between the majority of the team members and the newcomer, two philosophies of teamwork were identified; the integrative and the elective.

In the integrative philosophy, professionals held the following criteria as fundamental to teamworking:

- a commitment to two aspects of being a team member, the practice of a high level of collaborative care and therapy, and attention to team concerns
- a recognition of the different levels of role understanding and their importance in the development of negotiated role boundaries
- an equal value being assigned to each professional's contribution to both the patient's progress and to other professionals' development
- the belief that communication should include wide discussion and negotiation in order to develop a team understanding of the patient
- the awareness that attention should be paid to individual professional and personal concerns where appropriate.

All these combined to ensure that specific structures and processes were developed. These included forums for debate, shared case-notes, joint planning, monitoring and evaluating care, and joint learning.

The elective philosophy held the following criteria as important in order to work with others:

- a belief that autonomy of practice was synonymous with insularity of practice, thus inhibiting the development of shared vision
- an attention to role clarity which precluded the negotiation of role boundaries
- an ascription to a hierarchical structure of professions in which learning was valued from those of equal or higher status only
- the belief that brevity of communication in order only to inform others, was appropriate.

These beliefs combined to create distancing behaviours such as general lack of participation in the system, for example the withholding of case notes, and non-attendance at meetings.

The discrepancies of belief system between many existing team members and the newcomer were stark in terms of the differences this made to professional practice. The differences between those team members and some nurses were more subtle. The nurses as a group seemed to operated from a belief system which closely matched those of other team members, they ascribed to the integrative philosophy in many ways. However, there were elements of difference in the approach of some nurses which created some dislocation between themselves and the therapy groups. These differences related to a mismatch of directive expectations, and of knowledge and skills exchange.

5.4.4 Mismatch of directive expectations

The majority of team members assumed role parity in terms of team interaction. By contrast, some nurses behaved as if a hierarchical system was in place and they had secondary status. What encouraged this perception? It was clear that while many of the therapy group had a high level of confidence in their team contribution, some nurses felt unsure about their role. They knew what they did, but were unsure of their specific contribution over and above general patient care and being, as they put it, 'a therapy helper'. In addition to the lack of role clarity, this seemed to result in a perception that their input was less valuable than others.

It seemed that overarching this perception was a more diffuse uncertainty that they could practise without the direction of a more overt medical or nursing presence. Whereas the therapy groups were, at one level, operating autonomously, this did not apply to some of the

nursing group, who seemed to feel the lack of direction from above. This appeared similar to the way in which nurses were traditionally socialised to accept that the medical model, and those within it, directed their actions. This commonly held more sway than a belief in nursing as contributing from its own theoretical foundations, as an equal member of the multiprofessional team.

Within the rehabilitation setting, adherence to a medical model of care was not promoted; a more holistic problem-solving model took its place, in which any of the professional groups could have steered the care and therapy of the patient. It was true that from the problems identified on a patient's admission, plans of therapy were devised by therapists and expected to be carried out by other team members. In this way one could say that therapists prescribed team practice, but by the same token, plans of care devised by the nurses could also be continued by therapists. However, it was not observed that this actually happened. What were the perceptions of nurses that hindered their participation in devising team practice?

5.4.5 Mismatch of knowledge and skills exchange

As identified in much of the literature related to nurse/doctor interaction (Tellis-Nayak, 1984; Cambell-Heider and Pollock, 1987; Porter, 1991; Busby and Gilchrist, 1992; Mallik, 1992; Whale, 1993), this imbalance in status and the assumptions it implies about the prescription of others' actions, has led to specific differences in perceptions related not only to role valuing, but also to the limitation of communication. In some ways those findings were reflected in the way in which the nurses communicated with the therapy groups.

This did not mean that there was not a two-way flow of information and knowledge; nurses were frequently heard giving medical advice to therapists, and feeding back details of patients' emotional state or social difficulties. It was, however the emphasis on therapeutic prescription of practice which the nurses perceived and interpreted as undermining their standing in the team, inhibiting them from involving therapists in patient care. The nurses also assessed their patients and drew up plans of care and treatment, using the same processes as the therapists; however, their plans only defined nursing rather than team practice. In reality dealing with problems such as incontinence could have been defined as requiring team actions, but were not analysed in this way.

It was true that there was a strong emphasis on a physiotherapy-led approach to intervention; the achievement of quality mobility rather than functional mobility was considered vital to patients' progress. As a result, some nurses perceived the direction of education was also from therapists to nurses. The therapists were aware of the nurses' dilemma and sensitive of the need to be diplomatic when showing them new skills or imparting new knowledge. Despite these attempts however, skills or knowledge teaching was not observed to have been reciprocated by the nurses, and indeed was not identified as a common phenomenon.

As a result of perceiving themselves to be the receivers of wisdom in the team, some nurses behaved as if they had little of value to impart to other members. The therapists were keen to learn from each other, but this was accepted in the knowledge that they could teach others. The nurses did not seem to feel that they had a teaching role, because they did not think the therapists would be interested in details about continence or skin integrity. Thus the knowledge flow largely remained a one-way street.

One nurse who did not espouse to these directive beliefs had attended a specific rehabilitation programme of education, which gave her a clearer understanding of the role nurses could take. She was able to reflect more comprehensively on her contribution and to see herself as a rehabilitation nurse rather than a nurse who did rehabilitation; a difference which gave her confidence in her role.

From the beliefs that some other nurses held about teamwork some preliminary elements of a third philosophy was identified: a directive philosophy based on an assumption of

hierarchy where one person or group takes the lead by dint of status, and thereby directs the actions of others. Operating within this philosophy creates assumptions about levels of communication, since the person or profession in the lead position would determine what was communicated, and when and how it was communicated. It would also have the potential to determine the way in which professionals learned from each other, since learning from others would be defined by status. The philosophy made assumptions that roles lower in the hierarchy were valued for their service to the powerful role rather than having intrinsic value.

This philosophy is described further in later chapters. It applied most powerfully in settings where the medical profession was in positions of power, although as in the rehabilitation setting, it was possible for it to be perceived in situations where the reality of team interaction was not defined by this profession.

The development of these three philosophies of teamwork may to a large extent derive from the specific professional socialisation experienced by each group. However, later chapters illustrate that this was not the whole picture; members of professions who traditionally may have operated within a directive approach for example, were seen to have taken on different beliefs about multiprofessional teamwork. It would be possible to predict that where a group of professional hold similar beliefs about teamwork, it would provide a situation with reduced conflict of interest. However, where professionals who need to work together hold different belief systems, one could imagine the resulting difficulties which would arise. This issue raises an important implication for the education of health care professionals.

5.4.6 Learning implication

- Prior learning gives professionals different and potentially conflicting approaches to multiprofessional teamwork. It is necessary to understand the challenges which a mismatch of the various philosophies would pose to team effectiveness/efficiency in terms of overall strategies for present and future practice, and that effective multiprofessional teamwork derives from learning similar philosophies of practice.

Three domains of influence on multiprofessional working within the rehabilitation setting have been examined. Despite this team's difficulties, chiefly in relation to the newcomer, a highly collaborative level of working was achieved. How did this impact on patient care and therapy? In the sense that the team, for the most part, functioned smoothly, and all areas of clinical input were known and assimilated in order to form judgements and interventions, it seemed effective. In terms of monitoring the process of care and therapy, and the feedback of that process to all professionals, carers and the patient, that too seemed effective. It was also possible to identify a number of benefits which derived from this type of working, most of which had a direct impact on patient care and therapy, and one which more indirectly affected the patient. This is not to say, that patients cared for in a less collaborative way would necessarily suffer less effective outcomes. It is possible, however, to infer that the benefits described below would enhance the process of care.

5.5 The benefits of integrated working

5.5.1 Continuity

This related to the fact that professionals learned skills and knowledge from each other, which they could then 'carry over' when the 'experts' were not around. It could also be seen where a pattern of care needed to be followed with one professional performing an action with a patient which then enabled another professional to slot into the care with their own intervention.

For example, the nurses had learned from the PTs a method of managing patient transfers which minimised increasing the patient's muscle tone, by keeping the patient in a more crouched position and often giving more assistance than they might otherwise have done.

Initially this had been difficult for them to accept because it often meant encouraging the patient to be less independent than they need have been, and was sometimes extremely awkward for the nurses and patients. However, the lessening of muscle tone improved the extent to which PTs could work with patients in their own sessions, and resulted in a better quality of movement in the long term.

5.5.2 Consistency

This related to the fact that professionals learned about other team members' interpretation of patient difficulties, so that they were able to 'pick up' on patients' cues more readily in their own interventions, and act in a similar way to colleagues. For example, the new OT who had previously worked with comatose patients, had learned coma stimulation response techniques. Her arrival coincided with the admission of a patient with a severe head injury who was opening his eyes but apparently unresponsive. A joint session was arranged between the OT and SLTs, in which the OT demonstrated the process of establishing a yes/no response and gave other information on coma stimulation procedure and assessment. The OT then supervised the SLTs through the process, and they were able to use these same communication techniques in their own work.

5.5.3 Reduction of ambiguity

Because of the practice of joint discussion, joint working, and joint evaluation, there was also a high level of team knowledge. In this way there was no conflict in the message given to patients regarding their diagnosis or care. Further, the depth of role understanding within the team allowed individual professionals to explain each other's rationale of therapy to patients, which increased patients' perception of collaborative interaction. For example one observation session in the rehabilitation unit included a PT and an OT working with a patient on his standing position. They had been trying to massage the muscles on one side of his back in order to allow him to sit straighter, before getting him to stand in the same position. The PT left after part of the session. The patient then asked about what they were doing and the OT explained the principles of movement and how their techniques related to those principles. The patient later said that he felt secure because both professionals told him the same things, which made him confident that they were 'aiming in the same direction'.

5.5.4 Appropriate and timely referrals

Because each professional had a high level of knowledge of other professionals' roles, and boundaries, they were better able to judge accurately when it was appropriate to refer to another member of the team. Within this setting it must be remembered that each patient was assessed on admission by the various team members and a joint session was held in which specific problems were identified. Using this approach a number of professionals could be expected to work on a particular problem, with perhaps one taking the lead. The joint working practices which resulted from this session ensured that, as the patient progressed, individual professionals would be able to observe for themselves where they might take a more active role regarding a specific aspect of patient care or therapy.

5.5.5 A holistic perspective

The use of joint working practices made it possible to develop a picture of the patient which encompassed all aspects of self: the social, physical, and psychological. These multiple perspectives enabled decisions to be made using a wider knowledge base and allowed professionals to determine how aspects of that knowledge might combine to require professionals to take a different path of patient care. For example, where the PT and the SLT were discussing differences in a particular patient's scores it was realised that different parameters were being used to determine the scores, one looking at verbal interpretation and one involving the translation of a directive into action. As a result of the discussion, they were able to further specify the nature

of the patient's problem and work more closely on his lack of ability to make the link between what was asked of him and the actions he subsequently took.

5.5.6 Actions based on problem solving

The nature of the structures for focused discussion around specific aspects of patient care, and the subsequent dissemination of shared knowledge across team members provided a wider source of ideas about possible causes and likely actions. Further it encouraged the development of joint strategies for care and therapy.

This was seen clearly when team members were examining problem-solving skills in an education session. In terms of the way some nurses explored the nature of a particular problem, it seemed there was a lack of precision in identifying possible antecedents. This in turn, may have limited the multiprofessional work which could be done with the patient. Some other professionals in the team looked at the same problem and redefined the causes more broadly, allowing for greater multiprofessional input. Having identified through discussion which were the more likely possibilities, a strategy was developed for relevant professionals to have joint sessions with the patient.

5.5.7 Professional development

Many people in this setting spoke about their own professional development, in terms of both widening their knowledge base and skills, and developing a more complete understanding of the way in which one's own and other professionals' contributions improved patient care. Not only did watching different professionals in action profoundly change their understanding of others' roles in action, but it also forced reflection on their own practice because they had to explain to others what they were doing. Questioning what they were doing, and why, encouraged people to re-evaluate their actions with patients and to modify them if necessary.

Learning from each other was considered a vital aspect of collaborative working, and where it was seen, it was observed by professionals that they had become more confident in their own abilities. It required the type of team culture which existed in this setting, an open culture which provided a safe learning environment. Not only did professionals learn skills and knowledge, they were also encouraged to talk about more risky issues such as their own feelings, for example admitting that they could not cope, did not like a patient or think they were making a difference to a patient's progress, or could not manage the patient's despair or anxiety. Team discussion helped members by being mutually supportive regarding their experiences with a particular patient. Where it was experienced, this level of support maintained high job satisfaction, which has been linked with increased patient involvement (Hare et al., 1987).

These benefits to patients were identified by other multiprofessional groups in the case studies. However, they were only perceived to be facilitated where pockets of more collaborative working were in place. There were few examples of this working in Chapter 6, where fragmented working was prevalent, but they form the basis of the core work in Chapter 7.

Key points

- Lack of stability and predictability and the maintenance of monoprofessional structures suppressed opportunities for professionals to communicate consistently, efficiently and effectively.
- These factors also compromised opportunities for the development of role understanding.
- The medical model of patient care had an inhibiting effect on multiperspective communication. This was compounded by the communication style of some senior members of the medical profession.
- Power and leadership styles influenced the level of contribution to the decision-making process of the multiprofessional group.
- Where multiprofessional communication was superficial, mismatching individual belief systems had adverse effects on teamworking.
- These fragmented working practices suggested specific learning implications for students.

6.1 Introduction

The previous chapter explored some organisational and group factors which helped to promote a more collaborative approach to multiprofessional working which was termed *integrative*; it also showed how even under circumstances where the maintenance of this type of working would be likely, some professionals were unable to become as fully integrated as others. This related to issues around role, and individual philosophies of 'multiprofessional teamwork'. Although it seemed an effective way of working, it is not the object of this research to suggest that it is *the* effective way of working multiprofessionally. However, no other *whole multiprofessional group* in the research showed the same level of collaborative working. The difficulties of working together, and the resulting fragmentation of the multiprofessional group, seem more commonly expressed and experienced, rather than the form of working practices largely seen in the rehabilitation unit.

This chapter explores a type of multiprofessional working seen in three case studies and which in many ways represents the furthest point from integrative working. Since the nature of their working seemed to preclude calling them teams, they are referred to as multiprofessional groups (although two of these groups were designated as teams). One group was situated in an acute medical ward, two working side by side as community mental health teams (CMHTs) formed the second case study, and the third was professionals working in a primary health care team (PHCT). Although very different in terms of settings, structure and process, all exhibited *fragmented* working, resulting from different sources, but promoting group difficulties for them all. Section 6.2 outlines the multiprofessional groups; the three domains of influence are then addressed: the organisational, the group, and the individual practitioner. All issues subsumed under each section are introduced by evidence from the case studies, followed by discussion comparing and contrasting the way in which the issues impacted on aspects of the groups' function and its effects on patient care. Finally the implications for student education in relation to the three domains are given.

6.2 What the multiprofessional groups were like

6.2.1 The medical ward

The first case study took place in a 26-bed medical ward designated as a 'respiratory' ward. It was staffed by nurses operating in two 'teams', located geographically. There was also a four-bed high dependency unit (HDU), staffed by a semi-permanent group of nurses. Various consultants and their firms (doctors of all grades working under one consultant) visited the ward, as did PTs, OTs, SWs, a pharmacist, and several specialist nurses.

In the medical ward *perceptions of 'teamwork' were essentially monoprofessional*, and this was where primary allegiances were rooted. This perception was steered by the way in which organisational reality alienated professionals from each other. *Bed management* had created an *unpredictable* situation where patients with many varieties of illness were placed together to maximise bed filling. In tandem with increasing professional specialism, this meant that professionals, other than the nurses, attended many wards. In addition, nurses were unable to predict when of how often many of these professionals would attend the ward. This unpredictability resulted in lack of consistent professional interaction, such as nurses not regularly attending consultants' ward rounds, which frequently caused frustration at missed opportunities for information sharing.

The problem of uncertain timing and perceived large number of visiting professionals was compounded by the fact that many were on short rotations through the hospital. The effect of these factors was that *opportunities for forming sound relationships in which professionals could gauge the skills, competencies and knowledge base of other individuals serving the ward was much diminished.* In addition to this *lack of role understanding*, it was both observed and perceived that *ineffective communication and co-ordination of care* were frequent outcomes in terms of patient care.

In the uncertain environment created by the speed of organisational change, the *extension of certain roles* (such as nurse specialist roles) was also a cause for concern, and raised *professional defensive behaviour.* In this context, the ward nurses still perceived the specialists as 'nurse as doer' and found it hard to accept the premise of 'nurse as educator'. This created resentment and nurses were aware it could compromise patient care through an unwillingness to refer. There was also an indication of defensive responses being made by the medical profession as a result of the raising of the pharmacist's profile.

A final strand in this setting was the *continuing dominance of the medical model and the subsequent emphasis on medical input to patient care.* Despite negotiated decision-making being observed between PTs and OTs, nurses and PTs, and nurses and junior doctors, where overall strategies for patient care were decided, at the level of consultant, other professionals had limited input. This was related to *consultant style*, or attribution of consultant style, where nurses had at worst developed avoidance tactics, or at best offered information rather than ideas to the discussions.

Nurses' assertive style did make an impact on the amount and type of nurse input, as did the situation within the HDU, where continuity of the nursing staff, the small number of patients and consequently the small number of professionals who visited frequently, created opportunities for better communication and role understanding. In both of these circumstances, nurses spoke about or were observed to be offering suggestions for care procedures which were listened to and acted upon.

6.2.2 The community mental health teams

The second case study was of two CMHTs. These groups were designated as 'teams', so this term is used to describe them, despite the fact that they did not necessarily see themselves as teams. They comprised community psychiatric nurses (CPNs), SWs, an OT, and two

consultant psychiatrists (Consultant 1, and Consultant 2 for the purposes of comparison). They operated from two adjoining offices, and their overall focus, within a specific geographical location, was to manage the care of all people aged 18-65 years with severe or enduring mental health problems. They liaised with various other mental health facilities such as a day hospital, inpatient and outpatient sites.

Like the members of the medical ward, professionals in the CMHTs retained a *largely monoprofessional approach to patient care*. For example, referral, and allocation of clients to particular professionals was achieved by monoprofessional recording systems and meetings. All business meetings were monoprofessional, so that issues related to practice and professional concerns were discussed separately. Despite weekly case review meetings, which all professionals were expected to attend but many viewed as largely unhelpful, the different professional groups' day-to-day practice was conducted in a largely unconnected fashion. This was partly related to the large percentage of some professionals' case loads which related to *different population groups*, and because there was an understanding that, where the population group overlapped, it was interpreted as *duplication if there was both CPN and SW intervention*. As in the medical ward, the lack of day-to-day interaction resulted in a *paucity of detailed communication*, and a *lack of role understanding* created by the degree of hidden role.

This issue of duplication was related to a *shift in the CPN role* towards dealing with the more severely mentally ill, which meant that it was expected to encompass more social aspects of care. The CPNs felt they were unprepared, and not necessarily wanting to engage, in managing these aspects of care. As a result, *professional defensiveness* between the CPN and SW groups was rife, as both contested the interpretation of the keyworker role (part of the CMHT approach to patient care management).

The inclusion of different agencies in the teams led to difficulties regarding *policy decisions between the two agencies, differences in the documentation* used by the two agencies, and a *lack of communication between the two management structures*. These factors directly affected multiprofessional working in terms of highlighting the separation between the professional groups and creating resentments where decisions had been made unilaterally. Furthermore, *cultural differences* between the two agencies promoted discord around role definition and communication styles.

Finally there were tensions related to the *communication style of the consultant psychiatrists*, one being perceived as authoritarian and brusque, the other influencing multiprofessional interaction by attempting to *direct other's professional practice*, and indeed whole team practice. In both CMHTs, the consultant's communication style was interpreted by some professionals to undermine their professional judgement. The CPNs colluded to a large extent with these interaction styles, being non-challenging, and keeping communication to a minimum, meanwhile practising in an autonomous fashion themselves. The SWs and the OT perceived that these approaches inhibited their contribution, but to some extent did challenge the consultants. Particularly in the case of the SWs there were some angry exchanges in team meetings.

6.2.3 The primary health care team

The PHCT was situated in a large residential part of town, and operating from an old purpose-built health centre. It comprised two groups of professionals, one located on site, and one 'attached' to it. The first was the general practice group, which included a practice nurse, practice manager, and administrative staff employed by four GPs; the second were satellite professionals such as health visitors (HVs), district nurses (DNs), midwives and counsellors, employed by other organisations but 'attached' to the practice. Of this group, only the HVs had office space in the practice buildings. There was no explicit cohesive purpose for this PHCT, and no explicit shared philosophy of care. In addition there was no talk of *allegiance to the PHCT* from professionals on the outside, and little from those within the general practice.

This group's level of interaction was strongly influenced by *traditional medical attitudes* in which the there was an assumption that the GPs led and managed patient care, while other professionals contributed as and when required. This hierarchical view did, however, make some professionals feel secure in the GPs' support, and this was seen both in terms of patient care and professional support.

Unfortunately the *medical culture compromised communication* since some GPs perceived a one-way passage of information or expertise from the top down to be sufficient, and that willingness to share information and ideas was their prerogative. This was perceived to result in the GPs' unwillingness to hold whole PHCT meetings where their views or decisions could be challenged; this lack of interest in other professionals' views was not appreciated by other members within or associated with the practice. As a result, professionals trying to work with the GPs felt that patient care was managed on a day-to-day basis rather than professionals developing an overall strategy of care together. Where communication was effective, the satellite professionals in question had worked hard to *negotiate protocols* across organisations, having set up forums for discussion about subjects such as antenatal referral, and breastfeeding management.

The assumption of medical leadership also seemed to *diminish the doctors' needs to understand others' roles or to value others' input* as autonomous practitioners with their own ideas about patient care or practice management. Other role input seemed to be valued only in so far as it 'soaked up' aspects of the GPs' work which they *could* do but had no time for. This seemed, to other professionals, to lead to inappropriate referral and frustration at the lack of shared perspectives on care, and, in particular, limited the practice manager's freedom to shape the practice as an effective business.

Despite its isolation as a semi-urban practice, the GPs perceived pressure and interference from local health managers. In some ways the *actions of the health managers seemed counterproductive to the idea of PHCTs*, since monoprofessional working seemed to be more encouraged and GP attachment was inconsistent. There had also been many changes to the structure and process of some satellite professions over recent years, with the result that some professionals perceived there was *fragmented working*.

None of these multiprofessional groups appeared to engage in 'team practice' as defined by the rehabilitation team. All were to some extent hampered by organisational problems, particularly the medical ward; the CMHTs' and the PHCTs' problems tended to be at group level. However, all these groups' interaction was also influenced by differences in individual philosophies of multiprofessional 'teamworking'.

6.3 How the organisation affected teamwork

6.3.1 Lack of close working

In all other multiprofessional groups, lack of proximity, either in terms of practice, or of having a base, created difficulties. However, these groups were particular examples of how this issue could affect multiprofessional practice, either because organisational policy had enforced the transient nature of member's interaction within a central practice base, or because of the dissemination of members' practice from a central administrative base.

The medical ward, which supposedly specialised in respiratory problems, epitomised the difficulties in not working closely together in the same area of practice. Although all aspects of patient care (other than examinations performed in other units) were performed within the same geographical location, the bed management policy resulted in too many categories of patients being cared for within the ward since the policy was essentially designed to maximise the number of patients treated in the hospital at any one time.

It was perceived that, traditionally, patients had been admitted to small wards designated by type of illness, where they were nursed by staff skilled in their specific illness, and

where the nurses would interact with a small group of doctors, headed by a consultant specialising in that area of disease. In many wards this was not the case and to some extent it may not have been the rule for ward management, rather that the problem has been compounded by consultants having become more specialised, thus requiring the input of a greater number to a large ward.

This dispersal of patients meant that doctors and other professionals covered a larger number of wards, in some cases eight or 10 instead of one or two. The outcome for an individual ward was that a large number of medical firms and other professionals such as PTs, OTs and specialist nurses would need to visit as required. In fact it could be argued that this group should not be called a 'team' at all, since many professionals who attended the ward had no contact with each other, the single point of contact for all being the nurses.

How did the dispersal of patients affect the day-to-day running of the ward? For the visiting professionals, having to visit a large number of wards had ramifications for the amount of time spent in any one ward. For example, it was perceived that previously, a particular consultant's ward round and the pre-ward round visit by housemen and registrars would have taken an appreciable part of the day, since they would have been seeing a large number of patients. Now, fewer patients were seen by that consultant and his firm in a shorter time, yet at the same time, the nurses were needing to manage several similar events throughout the day. Interactions between various professionals were perforce brief, if there was interaction at all. Further, ensuring that, in the flurry of activities, the appropriate nurse was available to talk to the relevant visiting professional was extremely difficult.

The CMHTs comprised a small number of designated professionals who, apart from the psychiatrists, shared an office. By contrast with the medical ward however, they suffered from lack of *proximity of practice*, as clients were seen either at home, or in an outpatient facility. Occasionally they were seen in rooms off the office area, but this was solely a one-to-one exercise between professional and client. This type of practice would demand that professionals, at some point in their day or week, find time to discuss what they had, individually, been achieving with their clients. The central location of their administrative resources, i.e. their desk-space, case-note storage and computers, could have given the CPNs, SWs and the OT many opportunities for communication, however, the lack of proximity of practice was compounded by the comparative lack of joint focus in terms of clients.

Each professional would come to the office to make telephone calls, write reports and collect case-notes, but at no structured time; people came and went throughout the day. The SW group contrived to share lunch time together, but this was not part of the CPNs' routine. One morning in the week promoted proximity between all team members at the case review meeting, and this was cited by several members as being the only time they defined themselves as 'teams'. Since these meetings were themselves fraught with problems, the extent to which proximity served to promote effective multiprofessional working was limited.

In the PHCT only the GPs and the HVs were located in the same building; the midwife, DNs, and counsellors visited periodically to hold clinics in the practice centre, but were based in offices distant from the practice. Although these sessions were held regularly, so that other professionals could make time to discuss aspects of patient care, it was observed that these opportunities were not often taken advantage of.

Because of the peripatetic nature of several professionals' practice, communication tended to be by telephone, or written down; patients held notes made by the DNs and midwives, and there were a large number of books, one for each professional group, in which messages were passed to and fro. Of interest is the fact that one of these message books was used regularly by the GPs to communicate with the HVs who worked along a corridor from their offices. It could have been expected that those who were not actually based in the premises may have felt distanced from the rest of the PHCT, however, this applied equally to the HVs, who still felt outside the practice group of professionals, apart from the relationship they had developed with the practice nurse.

As with the CMHT, it would have seemed appropriate that time should have been allocated for these various professionals to meet to discuss specific patients, however, this was not the case, with people operating on a 'need to see' basis only. This lack of meeting time was identified by many satellite professionals as reinforcing the fragmented nature of their working.

Geographical proximity has been cited as a factor which helps to promote 'teamwork', particularly where people share working space and time (Abramson, 1990). In addition, a central meeting point where cases could be discussed in tandem with the potential to develop social relationships could be seen as providing the foundations for effective communication. Certainly the ability to take advantage of *ad hoc* communication opportunities and to watch others practising was seen to be an important factor in the development of 'teamwork' in the rehabilitation unit.

How did lack of proximity affect the multiprofessional groups? In the medical ward, because of visiting professionals' need to move from ward to ward, opportunities for communication were brief, and in some cases absent. The spread of professional input across the hospital meant that multiprofessional discussion around a particular group of patients was all but impossible, therefore it was hard for professionals to develop a multiprofessional approach to any one patient's care. In the course of the case study many instances were observed where information had not been passed between various professionals, or had been passed on incorrectly. This resulted in detrimental situations such as where a patient was 'fasted' for several hours unnecessarily, or where one missed a long-awaited appointment because the timing was misunderstood. All professionals acknowledged that communication was difficult, but had made little headway in overcoming the problems.

Since much of the multiprofessional group's practice was accomplished out of sight of each other, it was also extremely difficult for them to develop any understanding of what each other contributed to patient care. This was highlighted by the introduction of a discharge planning role where a specialist nurse co-ordinated the discharge of the elderly patients. She was aware that, despite the fact that she reiterated her role to nurses in the ward and other professionals on a regular basis, her role was largely hidden from any one group of professionals, making it hard for her to build up the credibility of her contribution to the process of care. Attribution of a successful discharge may or may not come to her, people would simply observe that a discharge process had or had not been achieved smoothly.

In the CMHTs there had been a purposive decision to bring professionals together under one roof in the hope of achieving greater co-ordination of service delivery. Despite the fact that these teams' practice was in general managed on a one-to one-basis with individual clients away from the office base, they could have benefited from a place in which to further discuss clients seen during the day. The teams were not, in general, offering an emergency service, therefore it would have been possible to set aside regular time for a daily 'debriefing'. However, team members did not identify a time other than the team meeting as useful for discussion, and communication in this latter setting was varied.

In one team's meetings, communication existed only as a means of passing on information and was bounded by the need to keep to a list of clients identified by ***geographical location***. This inhibited some professionals' input. The other team's meeting structure was more discursive and framed around the *process of care*. Despite this being potentially more facilitative of whole-team communication, other factors constrained communication, indicating that 'effective multiprofessional teamwork' is the product of a large number of interweaving elements.

A further problem related to the disseminated practice for the CMHTs (i.e. the domiciliary nature of their work) was the lack of opportunity for the various team members to develop an understanding of what each did. This was of a different order of 'not knowing' from the medical ward 'team', since the CMHTs were small, and nationally defined in terms

of who was a member, and what members' contribution would be. Chapter 5 identified different levels of role understanding. In this setting, role understanding, or lack of it, related to the way in which professional interaction in terms of practice would be largely unseen. This would limit understanding of the way in which the boundaries of professional roles would meet and/or overlap.

The situation in the PHCT was different in that, while much of the various professionals' practice was carried out in the domiciliary setting, there were several points in the day in which professionals could come together to discuss cases and develop an understanding of the role each was performing. For example, the midwife held a registration, and an antenatal clinic to which the HVs, the practice nurse or the GPs could have contributed. Likewise the DN's clinic could have been attended by the practice nurse or the GPs. However, this did not occur for reasons related to organisational policy, time factors, and a degree of professional defensiveness.

Communication in this setting was either written or managed by telephone, with *ad hoc*, and brief meetings between two professionals, in corridors and offices. Again because of the limited access professionals had to others' practice, there was limited understanding of what and how each contributed to the team's work; some professionals did not even know other members' names. Other factors contributed to this as is discussed later.

6.3.2 Lack of shared focus

When the word 'team' is defined, one common descriptor is that its members will share a focus of activity; most professionals, most of the time will be dealing with the same population of patients, therefore needing to discuss and co-ordinate their contribution to the care process. What level of population overlap was seen in these multiprofessional groups? One could argue that the members of the medical ward shared a focus in terms of patients on the ward. However, because of the various types of patients in the ward, and the variety of professionals caring for them, there were a number of foci.

From the description of the medical ward, it could be seen that the various visiting professionals would have a number of patients in wards across the hospital who would be cared for by a number of nursing groups. The nurses in any one ward would share their focus of care with whichever visiting professional was relevant to the particular group of patients. The number of visits to a ward, by a particular PT, OT, houseman or consultant would be determined by the number of a particular category of patient in the ward. In this way the shared focus of the 'medical ward team' shifted and altered as the population of patients changed. It was possible that there would be weeks in which the respiratory consultant, respiratory physiotherapists and specialist respiratory nurse for example, would be frequent visitors, however this was not always the case. The focus changed according to the nature of the patients in the ward, the only profession to have a constant focus in the one geographical place being the nursing group.

Within the CMHT, the shared administrative base gave an opportunity to discuss clients at some points in the day. However, there was little *reason* for communication, other than social interaction (the fact that this did not occur either, to any large extent across professions related to other issues discussed later).

As suggested in the brief outline of this team, the focus of the CPNs and SWs were either different, or, where they did overlap, clients tended to be taken on by one or the other. The CPNs were currently expected to be moving their focus from more mildly mentally ill clients referred by the GPs, to more severely and enduringly mentally ill clients who may well be referred via the consultant. Despite a supposed 20%:80% breakdown of their caseload into those categories, there was ambiguity about the extent to which this was achieved. Some CPNs said that this split actually defined their caseloads, others had a more equal split, meaning that the number of clients shared with other professionals would be smaller. Other professionals in the team perceived that the split was *more* in favour of the less severely mentally ill which, they

felt, resulted in the CPNs having a more rapid turnover of clients through the use of short-term structured and focused work. The potential for others to share a focus for 'teamworking' with the CPNs was therefore uncertain.

The SWs by contrast had smaller caseloads of clients, the vast majority of whom were severely or chronically mentally ill. Client turnover was very low since they dealt to a large extent with people living in assigned long-term residential accommodation. Both the consultants and the OT shared the clients of the other professional groups, so that their caseloads spanned both. In effect, their communication was with either one of the professions but seldom both.

In the PHCT each professional group took a part of the focus of the general practice (in which each GP had a separate list of patients). The HVs saw all families with children under five, from the GPs' lists, and the midwives shared the care of all the GPs' pregnant patients. This group of professionals thus overlapped to some extent in terms of patient group. Apart from their obvious overlap with the GPs, the DNs had little in common with the midwife or the HV, their chief area of work being the management of people discharged from acute care, and the chronic and elderly ill. The counsellors could have overlapped with any of the professional groups, but tended to take their referrals from the GPs, and since the feedback of these referrals was kept between the two professional groups, others would not have known about the overlap.

The very nature of combined practices means that while some patients will be seen by various GPs in a group, in general terms they work as autonomous practitioners with their own lists of patients, and to whom the other professionals offer a variety of services. Many of these are aimed at different populations of patients. In some ways this reflects the situation in the ward setting where the nurses were the profession with whom every professional had contact, but did not need necessarily to be in contact with each other.

How did different focus affect the multiprofessional groups? For the CMHTs, the most problematic outcome was the lack of identification of exactly where the various professionals shared clients, and where they did not. It was possible that people could be receiving either multiple input where less was necessary, or inadequate input. With some professional groups working 'in the dark', this could have given rise to ambiguity of messages from the various professions, duplication of effort due to unacknowledged role overlap, and thus reduced time for other client input.

There was also the potential that professionals may wrongly assume that someone was seeing a client. Even if the teams had a tight focus for their input, still case review would have been an important process for identifying progress or otherwise. In a situation with different foci for care, it would seem to be a major omission. Since neither CMHT employed a comprehensive case review system, it was acknowledged that some people 'slipped through the net'.

Where the client group was seen to overlap for the CPNs and SWs, this raised the issue of which professional would take a key role. The issues stemming from the introduction of this keyworking system are dealt with in Section 6.3.3, but it was perceived as a role which to some extent, obviated others from active input, giving rise to the either/or aspect of professional intervention.

The lack of shared focus made it difficult for the ***multiprofessional groups as a whole*** to grasp the work of other team members. Fundamental to the success of multiprofessional teamwork would be a single purpose for action; a shared focus for whatever work the team would decide as appropriate (e.g. Schein, 1985; Poulton and West, 1993). Where only some professionals in a team share a patient or client group, then 'teams within teams' may develop. Only these would need to communicate in a detailed fashion and understand what each professional was bringing to the care of *their* patients/clients. Where the focus of 'team members' varies and changes, and those professionals within 'the team' do not *need* to communicate with each other, then the entity known as 'a team' does not actually exist. This was reflected by the nurses

in the medical ward who described 'the team' as all those who came into contact with all their patients – almost the entire hospital staff excluding nurses.

Although the multiprofessional groups varied from a small designated group of professionals, to a semipermanent larger group in the PHCT, to an amorphous and shifting number of professionals in the medical ward, in none was there a sense of ***belonging*** to a 'multiprofessional team'. Although other issues impacted on the difficulties of these groups developing a feeling of being 'in a team', the *lack of shared focus* would seem to be an important missing aspect of the substructure.

6.3.3 Lack of predictability

Both the CMHTs and the PHCT to a large extent existed within a prescribed structure of clinics and other sessions, sharing a level of predictability not seen in the medical ward. Lack of predictability in this setting was a major cause for concern since nurses did not know when other professionals would come to the ward, nor who they would be. By the same token, despite a named nurse system, the shift rotation of nurses meant that visiting professionals did not know who to go to for advice and information.

In the former case, lack of knowledge about when various professionals would be coming to the ward was compounded by the fact that visiting professionals did not demonstrate consistent patterns of communication with the nurses. Some would wait until a nurse was available to inform them of what had occurred and any decisions made; others did not. The nurses, since they were often engaged in caring for patients with the bed curtains pulled, often did not realise that other professionals were in the ward.

For many visiting professionals, it was simpler to write in the medical notes and assume that the nurses and other relevant professionals would read them. Some drew attention to more traditional structures where the ward sister had been the central focus for information-sharing and decision-making. In tandem with a system where ward round times were known, it was possible to have an arrangement whereby this senior nurse would routinely be available.

How did the current situation affect professional interaction in the medical ward? The difficulties experienced in the ward resulted in many missed opportunities for communication and subsequent inconsistencies in patterns of care, some of which were vital for the patient's well-being. For example, one of the respiratory PTs expressed concern that the lack of communication had led to disjunction in the care process. She spoke about her difficulties in linking her intervention with that of the nurses, in order to maximise the effects for the patient.

She came to the ward to perform chest exercises with particular patients which required the prior giving of drugs through a nebuliser, which was to have been organised by the nurses. The PT had indicated that the drugs needed to be given about an hour prior to treatment to maximise the effect of the exercises. She felt that the nurses were often late in doing their drug rounds, so that when she arrived not enough time had elapsed, or the patients had not had the drug at all. In either case, there was the possibility that she would be unable to do the treatment on that day. However, the PT was also observed to attend the ward in a random fashion, sometimes early in the morning, others not until the afternoon. When the nurses were asked at what time they would expect the PT to visit, they expressed no awareness of a particular pattern.

As a direct result of not knowing the pattern of professional input, and the subsequent missed communications, nurses would need to contact professionals at times when they may be busy on other wards. For example, they regularly contacted doctors using their 'bleep' system. This was a source of frustration for the nurses and resentment for the doctors. Some of these professionals were clearly stretched with work in other areas, and felt that the nurses did not understand how hard they *were* working, and as a result contacted them unnecessarily.

The ward's HDU did provide a more cohesive approach to patient care where communication seemed more effective and role understanding was more developed. This unit took a small number of seriously ill patients who needed more intensive nursing than was possible on the open ward, and a relatively constant small group of nurses managed four patients in a one-to-two ratio. There were also fewer visiting professionals, making frequent visits during this crisis period. In effect they had created a similarly focused and specialist approach (albeit over short periods) as was seen in the rehabilitation unit.

Nurses in the unit contrasted this approach to working in the main ward, and spoke about the benefits of continuing interaction with a specific group of professionals, their satisfaction with working in this intense fashion, and its benefits for patient care. They could see that they were not only able to develop a close relationship with patients, and therefore to more accurately monitor their progress, but that they had developed a more in-depth understanding of what other professionals contributed to the process of care. In addition they felt able to contribute detailed information and observation of the patient's condition.

By the same token, those professionals who dealt with them felt that the HDU nurses had a more comprehensive and up-to-date picture of the patient, and were better able to respond appropriately to other professionals' queries and advice. Furthermore, visiting professionals became more confident that the nurses would be able to provide continuity of care in their absence.

Apart from the HDU, it can be seen that unpredictability resulted in severe limitations on the level of communication and the knowledge which individuals within this 'team' could develop about other professional's practice, i.e. their roles in action. For the greater part of the working day, these roles were hidden from each other. When visits *were* made by other professionals, they were often brief and unexpected, which compromised nurses' availability to attend the patient, and so witness what the professional was doing, and how. This 'unseen' aspect of others' work created the potential for resentment, which is discussed in Section 6.3.4. It related to the issue of competing priorities for care, the outcomes of which professionals found hard to convey to each other.

6.3.4 Competing priorities outside the multiprofessional group

Professionals in all settings had to cope with competing priorities for their time in a specific multiprofessional group. Many professionals who came to the medical ward had patients in other wards. For example, it was common for nurses to complain that they could never access housemen easily once they had left the ward. Although the doctors had pagers, because of other calls on their time, some of which may have been of a more serious nature than they would deal with on the respiratory ward, nurses could wait for some time before the doctors came to see their patients. In situations where the nurses felt they had to 'badger' the doctors, and where those doctors did not attend for some hours, the nurses had developed the system of writing every attempt at communication in the nursing Kardex. One doctor perceived this as defensive behaviour i.e. the nurses protecting their professional reputations, and which became a stick to beat the doctors with.

A similar situation was observed within the CMHTs. The SWs had extra qualifications as approved social workers (ASWs) which gave them powers to 'section' people with severe mental illness needing inpatient care. This system operated separately from the work of the CMHTs, as part of the social services mental health resources. The SWs were regularly 'on call', when they were expected to prioritise their ASW work over that for the CMHT. This could mean that SWs were absent from team meetings or ward rounds. While this seemed to be accepted, or at least not commented on adversely by the CPNs, one consultant (Consultant 2) was extremely frustrated by the way in which this (and other priorities such as training) took the SWs away from what he perceived to be important times for discussion. Several ward rounds were observed where discharge planning of a particular patient was necessary and SW

input was crucial in determining factors such as the accommodation obtained, follow-up resources available, and financial arrangements made.

In fairness, the SWs also found their ASW work competed inappropriately with their time in the team, since it frequently interfered with appointments with clients. It also meant that information which should have been given at the meetings had to be relayed by written report or telephone, taking more time from the already limited amount they had for the team's work.

In the PHCT there had been several changes to the designation of the various professionals. The DNs had, until a few months previously, been geographically attached, which meant that within a large group of nurses, they were responsible for 20 general practices. This had changed and two of the original group had been allocated to this practice only. The midwife was part of a small group responsible for three general practices. Although she was the chief midwife for this practice, it was also likely that one of the other midwives would attend clinic sessions. During the course of the study there had been a several changes in membership of the midwifery group, and in tandem with the number of midwives attending the practice, at no clinic session was the same midwife seen more than twice.

How did competing priorities affect the multiprofessional groups? In the medical ward, those left to manage problematic situations, i.e. the nurses, felt that visiting staff did not always give the ward sufficient priority. This did not help the development of 'team cohesiveness', instead a monoprofessional stance was reinforced, especially between the doctors and nurses.

Those who had worked in the hospital previously remembered that communication with other professionals had then been predictable: those on the ward could be sure that their queries would be answered and prescriptions filled for example, at certain times. Not knowing where other professionals were, nor why they would not come to the ward, had forced the nurses into the defensive behaviour described above. Competing priorities, particularly when geographically distanced, seemed to be highly detrimental to the development of a sense of cohesiveness between professional groups. Although those on the ward may have understood the diverse nature of the doctor's role, accepting it when they needed doctors' input as a 'team' member was far harder to deal with.

In the CMHTs, the lack of SW input at ward rounds severely hampered professionals ability to make comprehensive decisions; how could they confidently time a client's discharge without knowing what accommodation had been found, what carer support had been arranged, or what financial assistance the person would receive? Since the client always attended this meeting, it also meant that the SW was unable to gauge their condition, and whether discharge was appropriate. The following situation shows how SW input could have shaped the decision-making process differently. The consultant and a SW had separately seen a client who had attempted suicide. The consultant's diagnosis was that the man had a personality disorder, which led him to believe that this was attention-seeking rather than a serious attempt to kill himself. In the ward round the consultant wanted to arrange for their discharge but was unsure how to proceed since the SW was not available. Without specific information from the SW he could not know that the man had been in alcohol rehabilitation where he had been extremely depressed and had made previous suicide attempts. Vital information such as this would have allowed the consultant to have made a more accurate judgement of how best to manage the man.

How does a team develop a sense of integration if its members are needing to focus regularly on events outside the team? Within the rehabilitation team, prioritisation was not only firmly located within the rehabilitation specialism, but further, it related to specific patients within that specialism. This sharp focus helped to foster the attention to patient needs as a primary goal for *the team*, rather than as individual professionals. The creation of smaller teams of professionals who focus their activities around a small number of patients may not only help

to sustain a high level of cohesion among professionals, but also ensure that patients have a sense of *their* nurse, or *their* OT within the wider framework of *their team*.

6.3.5 Lack of supportive management structures

Within the rehabilitation team a joint management structure had developed, overseen by a facilitative leader. This provided the opportunity to develop 'team practice', and to encourage team allegiance equal to professional allegiance. Within the multiprofessional groups described in this chapter, there was no such unifying structure.

Before beginning this section it should be stated that the term 'lack of supportive management' is not intended to relate to support for an individual professional group; indeed some of the actions taken seemed to be promoting the development of a particular profession. However, in terms of the development of *multiprofessional* teamwork, unilateral decision-making, no matter how positive, seems inappropriate.

So how did separate management structures impact on the multiprofessional groups? First, they were seen to create a basic difficulty for multiprofessional groups by fostering the persistence of monoprofessional structures and processes, inhibiting groups from developing coherent practices or a sense of 'team' allegiance. Second, because of unilateral decision-making, separate management structures created interprofessional conflict. Although separate management was generally perceived to be divisive in nature, only in the PHCT and CMHTs, did this extend to conflict within the groups.

6.3.5.1 Monoprofessional structures

In the medical ward, none of the structures or processes supported the development of coherent practice or an allegiance to the multiprofessional group. For example, each profession had its own system of record-keeping supervised by its professional management, in which case discussion was generally monoprofessional. Although there were supposed to have been regular multiprofessional 'team' meetings, none took place during the study. When investigations were made as to why this was the case, the ward manager discovered that the specific respiratory 'team' meeting had been disbanded due to lack of attendance. The elderly care 'team' meeting, (which may have been related to some patients in the ward) had moved to another venue, about which there had been no information.

In the CMHTs, all structures and processes (apart from a weekly team meeting) were monoprofessional. This included separate referral, allocation, and assessment procedures, in addition to separate business meetings. In these meetings, team practice would be discussed in relation to the particular professional group, not the CMHT.

In the PHCT, apart from regular meetings between the HVs and the midwife, there was no regular case discussion between any groupings who would have had cases in common. The few meetings in this setting were also largely monoprofessional. There had been the recent introduction, by the community trust, of a meeting designed to encourage better collaboration between general practice and satellite professionals such as DNs and HVs. However, it was at an early stage in its development, therefore it was not possible to predict how effective it would be.

The extent of professional separation was highlighted by one incident in the CMHTs. The teams were relocating to a new hospital and had been invited to look at their new offices. This was promoted as a 'whole team' day out and yet when team members arrived at the hospital, the SW manager and the CPN manager each took their professional group to discuss practical issues relating to 'teamworking'. When asked why this had occurred, the CPN manager said he felt it was *'not my place'* to ask the SWs to join the CPN group. Such actions do little to foster a sense of belonging to a unified group of professionals.

A result of separate management structures where various strands were not in communication was that 'grass root' changes to multiprofessional team practice would be hard to achieve. Even if a multiprofessional group sat down and devised an approach which required changing multiprofessional structure and process, how would that be achieved if management did not meet to discuss and agree the changes? One of the CMHTs had spent time the previous year developing joint approaches to client care; a main proposal of which was putting a 'team co-ordinator' into post. The resulting document was given to both sets of management, and but little was fed back to the team, nor were the ideas implemented (other than changes to an existing structure).

6.3.5.2 Divisive decisions

A second outcome of separate management was the likelihood of unilateral and divisive decisions. The changes within both the DN and the midwifery attachment to the PHCT have already been described. The shifting nature of the professional input to the 'team' had been difficult for the GPs and satellite professionals. In addition, the doctors had become concerned about changes in the DN and midwifery roles, to which they had made no contribution in terms of the decisions made. They remembered a time when they had seen one or two designated DNs whose role was wide-ranging and flexible. Now DNs were required to conduct a full assessment before they could visit a patient regularly, making it impossible for the GPs to request the DN simply to *'go and take out some stitches for us'*, or to do *ad hoc* dressings. In effect the DN management had reduced the DN's 'handmaiden' image by ensuring that this professional employed the same system of referral and assessment as other professions.

The GPs in this setting decided not to co-operate with the decision by preventing their practice nurse from doing such dressings as part of *her* practice. They did this because they were concerned about the implications for their own workload, and that of other professionals within their staff, since the work still had to be done and they had only a limited number of practice nurse hours. The practice nurse was unhappy about this restriction to her work and felt that it had alienated her from the DNs. It was a case of both professionals feeling that the other ought to be fulfilling this role.

A second management decision which affected this group related to changes in the midwifery service. GPs felt *'left in the dark'* about what these changes meant for their practice, but above all were aggrieved at the lack of information from midwifery management. For example one midwife attending the practice at the beginning of the study, was requested to withdraw her services in order to rationalise the delivery of care in the area. She left without saying good-bye to any of the multiprofessional group, who did not know who was coming in her place, nor when they were arriving. Only the HV had been informed of the situation and this reflected her rather closer relationship with the midwife.

When the new midwife arrived she presented the GPs with a new protocol for shared care, developed by the local trust, and requested that they all meet with her to discuss it further. This protocol was developed without input from the GPs, despite being called 'shared care'. One GP was particularly angry, since on first reading it appeared that the changes would restrict medical input until late in pregnancy. For this GP, who took a great deal of interest in ante-natal care, this was not acceptable. Fortunately, an agreement was reached between the groups, but in terms of multiprofessional working it did not seem appropriate that the situation developed in the first place.

In the CMHT, the process of decision-making at separate higher managerial level also seemed more intent on strengthening the divide between professionals than supporting more joint working. For example, there was no discernible feedback of information between health and social services management during the study. As a result of a redrawing of the consultant boundaries, the social services required the removal of some SWs from the teams. The subsequent strain which that might put on the team resources was not discussed with the

team (in fact it was not even discussed as a SW concern). This apparently arbitrary approach to decision-making, which affected the whole CMHTs, was extremely frustrating for team members. How did that affect interprofessional relationships?

Where decisions are taken by separate management structures which affect only one professional group, and in ways which are detrimental to the multiprofessional group as a whole, this would be likely to drive members further apart. In the CMHTs, although they could understand that the SWs were individually affected by the reduction in their manpower, and finding it difficult to meet the demands of their new workloads, the CPNs still became angry at perceived lack of support from the SWs over issues such as housing and finance. As 'grass roots' workers, however, they felt largely impotent to make fundamental changes to their practice which could help overcome the problems.

Separate line management has the potential therefore to create two difficulties for multiprofessional teamworking: the practical problem of inhibiting change, and the other creating interprofessional conflict, thus sustaining a mind-set which views team allegiance as less important than monoprofessional allegiance. This would govern the level of effort and commitment to a particular team (McGrath, 1991; Delaney, 1994; Pritchard and Pritchard, 1994). While much can be done on a group level to foster the growth of a 'team' culture such as that seen in the rehabilitation unit, there also need to be supportive organisational structures which help professionals to look inward to the team as well as to their own profession.

Clearly, aspects of organisational structure and process could be detrimental to the possibility of developing 'effective multiprofessional teamworking'. First, they could constrain professionals from engaging in comprehensive and consistent communication. Second, they could limit the development of an understanding of each other's roles; this would involve not only understanding how each person in the group contributed to patient care, but also what that person's role entails and the rationale behind their actions. Finally they could affect the evolution of a 'team philosophy' where, through discussion, the group agrees on its approach to care and how that affects individual practice.

If professionals do not have opportunities to meet because they are geographically separated, do not share a focus for their work, have competing priorities outside the multiprofessional group, and are further divided by separate management, how would 'team' function be fostered? If the push towards multiprofessional teamworking is a real phenomenon, seen as essential to enhance patient care, strategies are required which support the growth of this type of working. Further, those coming into health professions should be given a clear understanding of not only the requisite knowledge and skills of how to be a team member, but also means of coping with the organisation in which 'teams' function; i.e. they should be encouraged to learn strategies for managing the possible fluidity and unpredictability of their environment, and the conflicts which may arise as a result.

6.3.6 Learning Implications

- There are ***differences and similarities*** across the spectrum of 'teamwork', from the well-defined and close-knit model to the looser and more fragmented model; from the hierarchical to the flat models of teamwork.
- The ***context within which they are operating*** in teams, that is the organisation, its policies, structures and processes, might impact on the team in various ways.
- There is a need to develop strategies to deal with the ***fluidity of the organisation***, i.e. the management of change. This may mean being more open to more fluid role boundaries.
- Best practice in terms of teamwork may not be possible to achieve in all environments. ***Stability and predictability*** may need to be present to a certain degree to allow teamwork to develop in this way, as may the team and its members having specific designation.

- The *importance of dealing with inconsistent communication* should be acknowledged by the use of more structured approaches. Thought should be given to how professionals can overcome difficulties in the following situations where:

  1. the depth and breadth of communication differs from person to person, as in nurses' handovers
  2. professionals are inconsistent in recording their interventions, as in which documentation is written in by which visiting professional
  3. professionals come together to share information and ideas, as in ward rounds.

- The benefit of *developing communication styles which maximise all professional input* into the decision-making process regarding patient care should be recognised. For example, the need to develop more assertive styles when dealing with professionals perceived to have status and power within the organisation, and the need for those professions to develop more facilitative communication styles when dealing with professionals perceived to have lower status.

- The significance of *identifying strategies to overcome the lack of opportunity for the development of role understanding* should be recognised; to understand the issues related to the fragmented teams in the following situations:

  1. where professionals are peripatetic and much of their role is hidden
  2. where new professional roles are introduced.

- The *problems of managing change* should be recognised. Since many professional roles have shifted, or extended, those who encounter these both from a subjective and from an objective position will be likely to experience dissonance.

6.4 What it meant to be a 'team' member

The degree of fragmentation experienced by these different groups of professionals made it extremely difficult for any to form what could be defined as a team, people who shared a common goal and were working *together* towards that goal. For the medical ward in particular, it was very hard for them to identify 'team membership' since this shifted according to the composition of the patient groupings. Lacking a sense of 'teamness' meant that monoprofessional orientation was high, and that professionals' attention to group processes was also monoprofessionally focused.

The degree of awareness of any group as an entity would determine the level to which members would associate themselves with that entity and so be affected by its dynamics. For example, if the professionals working in the medical ward had a sense of 'teamness', then *integration* into that 'team' would have been an important issue for them. However, 'belonging' in that situation was primarily to one's own professional group. To a large extent this held true of both the CMHTs and the PHCT. All operated from a *monoprofessional 'them and us'* position, and the group issues discussed in this section must be seen from that standpoint.

For the CMHTs and the PHCT, the former was organisationally defined as a team; the latter had been historically, but now seemed to be a looser formation. Both groups had several foci, which resulted in only some professionals sharing a goal rather than the groups as a whole. Furthermore, where goals were shared, there were often different understandings of how they would be reached since the different philosophical stances of the various professional groups were not resolved. Conflict and/or distancing mechanisms were rife in these groups.

This section addresses issues around the *beliefs and values* of the multiprofessional groups, *leadership and power, role boundaries and the problems related to change*, and *integration processes*. The way in which these issues affected communication, and role understanding is then discussed.

6.4.1 Beliefs and values: 'team' vs professional

In the formation process of a team, members will develop 'ways of being'; that is, a number of shared beliefs and values (Brown, 1988). This is part of what defines any focused cohesive group, that, as a member, one will abide by the 'way things are done'. This was clearly demonstrated in the rehabilitation team, indeed to the extent that selection procedures attempted to ensure that new members would 'fit in'. In none of the groups in this chapter was a whole multiprofessional group 'way of being' identified.

Because of the distanced nature of their interaction, the beliefs and values of the separate professional groups in the medical ward were not accentuated through being brought into conflict or agreement with each other (however, the assumption of primacy among the medical profession and its effect on other professionals is discussed later in this section). They rarely interacted in a way which made these beliefs visible.

The CMHTs, despite their fragmented activities, at least had an *organisational* awareness of being a 'team'. They were geographically located together, defined in documentation as a team, and met weekly as 'teams'. However, to all intents and purposes, team members took divided stances, often seeing other professionals within the group as 'other'. Since, however, these groups were forced to interact regularly, the nature of their separate 'ways of being' were more readily visible. These affected both 'team' relationships, and the way in which clients were dealt with.

Because of the weekly meetings in the CMHTs, and the subsequent visibility of professional interaction, it was possible to identify some aspects of two cultures in conflict; i.e. health and social.

6.4.1.1 Beliefs about client rights

The chief 'value' difference related to a social work approach to clients' rights, and the challenges to medical power within that. The 'medical model' tended to hold that a range of mental illnesses had a biological base, and were treatable with medication. The SWs' more sociological belief system held, that people's family and social environment could lead to mental illness, and that by changing those elements, people could be assisted towards better mental health. In this setting, the consultant psychiatrists and SWs generally stood either side of the middle of the nature/nurture spectrum rather than being polarised. This cultural attitudinal difference has been noted in other research (e.g. Wilmot, 1995).

The ways in which these differences manifested themselves were frequently seen in team meetings where there could be heated interactions about the 'right' approach to managing care. However, it was most obvious in the determining of a client's ability to decide whether or not to have medical treatment for their severe mental illness. The SWs promoted the client's right to choose for themselves, seeing it as their duty to preserve this right by supporting the client in the community, offering more secure housing and the input of other community workers. If those options failed, the SWs would attempt to persuade the client to go into in-patient facilities *voluntarily*.

The consultant psychiatrists would tend to promote clients' care from the position of managing their treatment *for* them. This could lead to 'sectioning' them and enforcing drug treatment until the consultant felt they were in a position to make more rational decisions. These two positions were not always at odds; both the SWs and consultants commented that frequently they were of the same mind. However, many SWs believed that sectioning in order to force medication was used more frequently than necessary.

The rigorous adherence to the medical model was also queried by some CPNs, who ascribed to a more psychosocial model of care, indicating perhaps that they had begun to develop more common values with the SWs. Some proposed that diagnostic and medicating decisions were based on uncertain understanding of the causes and processes of mental illness, and it

conjured a picture of psychiatry to some extent 'stabbing in the dark'. It would seem that the confidence with which decisions were made by the medical profession may have *needed* tempering by other input from the multiprofessional team.

Both the SWs and the consultant psychiatrists made an assessment under the Mental Health Act, with the SW making the application to section. Thus the SWs needed to agree with the medical opinion in order for 'sectioning' to occur. The differences in belief systems underpinning the different roles which the two professions took in this decision, therefore had the potential to lead to conflict. Further, the action which SWs took as a result of their different orientation may have been perceived as a challenge to consultants' professional autonomy. This highlighted the perceptions of role contribution of the two professions to the 'team'. Some SWs felt that the traditional hierarchical position which existed between the CPNs and consultant psychiatrists was not reflected in the SW and consultants' roles. They felt they had greater parity with the medical profession. The CPNs were, however, seen to be 'on the same side' as the consultants, sharing to some extent the medical model of care. As a result SWs were a small professional group, who felt they could, and needed to, challenge the *status quo*.

6.4.1.2 Beliefs about importance of contribution

There was an assumption by the health professionals, that their input made the most important contribution to the team's work, with the SWs providing simply 'housing and finance' needs. There were differences in balance between professionals' perceived required input which created tensions in meetings. This was interpreted by some SWs as minimising the chance of their opinions being listened to, a perception which was reinforced numerically. In meetings they were frequently the only SW, and some did not feel: *'as if we are part of this family in many ways'*. In this situation, because support from CPNs was not common, SWs found it difficult to maintain an argument. They also did not feel that the consultants valued their opinion. These perceptions were reinforced by observation of interaction between some SWs and consultant (Consultant 1) in particular.

For example at one team meeting, the SW suggested that a client who was making little progress but who had an evident alcohol problem, should see the consultant from the alcohol rehabilitation team; Consultant 1 became angry as he seemed to interpret the suggestion as a slur on his own expertise. The SW tried to counter that the other consultant had different expertise and she would expect someone to make similar suggestions to her if it was relevant. After a terse comment, Consultant 1 said he would not agree to this course of events. There seemed to be no way that the SW could take this opinion forward and she left the meeting feeling undermined, and disappointed for her client.

Because communication between the SWs and both consultants was problematic, the SWs' response was to 'vote with their feet'. While maintaining that they did not have time to attend meetings and ward rounds (which may to some extent have been true), they also found the antagonism in the meetings and ward rounds difficult to manage. The ramifications of this can be seen in the following scenario. A client had been admitted to the inpatient facility having been found on a bus, overdosed on medication. He had been known to the mental health services in his home town some 200 miles away. At the ward round, one week later, Consultant 2 wanted to discharge him back to his previous inpatient facility in his home town or organise some accommodation in the local town. To do this he needed to discuss the case with the client and the SW present. Because of the SWs lack of consistent attendance at ward rounds, this discussion could not take place. The consultant was angry that ward rounds had become essentially himself and one nurse making decisions without other professional input, but did not make the link between his perceived attitude towards the SWs and their response by keeping a professional distance. The SWs' action was commented on unfavourably by both consultants and did nothing to help an already antagonistic situation.

Another difference between the professional groups' beliefs and values was in the management of anxiety and anger. This created misunderstanding between the groups. During the period of this study, there were many changes to the 'teams', including reorganisation into smaller groups, removal of some members to another area, and a move of remaining members to a new site. Both managers and consultants were blamed for the way in which the changes were handled and the CPNs and SWs were anxious and angry as a result.

The SWs and the new OT expressed their feelings openly however, as they did about many other aspects of their work. The CPNs also expressed anxiety and anger, but seldom in the open arena; they chose to speak among themselves. The different approaches had different interpretations. Since the SWs and the OT were in general very vocal, often discussing their feelings about a particular client and the management of the case, they obtained support from other 'team' members. However, this was sometimes interpreted by the CPNs and their manager as 'spilling out' inappropriately. Indeed some felt that this vocalisation was unprofessional.

By comparison, the CPNs' apparent silence within the 'team' was interpreted by the SWs as apathy; the CPNs were seen neither to challenge the *status quo* by themselves, nor to be prepared to act with the SWs and OT. Thus their response was seen by the SWs as frustrating, and as a lack of support on issues common to both professional groups within the team setting. Furthermore, the CPNs' silence was sometimes construed by the SWs as deferral to the consultants, since the latter's behaviour often prompted the anger in the first place. Where the SWs expressed their feelings openly to the consultants in meetings, the CPNs felt this was damaging. Neither professional group felt that open debate of feelings was 'safe'; the CPNs coped by remaining silent, and the SWs by largely taking themselves out of meetings. Observation of meetings identified extreme tensions which were never resolved. The lack of unified response across the SW and CPN professions may have been an important factor, as was the difficulty shown by the consultants in promoting debate.

The different sets of beliefs and values existing within these CMHTs had a stifling effect on communication, promoted misunderstandings and reinforced the different role values placed on the different professional groups. In terms of communication, not only did the lack of open debate provide a climate in which communication could be missed, but also because of the nature of the differing approaches to care, there was the possibility that ambiguous messages could be given out, causing confusion to both clients and their carers. This leads to a final point about the way in which the CMHTs operated; that the divisions between professional groups in terms of their values and beliefs seemed to override the need for the team to provide *a patient-/client-focused approach as a team*. While it was clear from observation and comment in the case study that each group, and within that, each professional, had the client at the forefront of their practice purpose, this was by no means obvious as a *team* commitment. 'Jockeying for position' between professional groups discouraged a common approach being taken, as was commented on by those on the periphery of the teams, or newcomers.

6.4.1.4 Belief in putting the patients first

In the PHCT, since they had no regular interaction as a group, areas of tension in terms of beliefs and values were rarely visible. One major exception is discussed in the section on individual philosophies of teamwork. However, it was evident that a patient orientation existed within the practice. This does not mean that there was multiprofessional attention to patient's pathways of care, rather, that patients were *'put first'* by individual professionals. This had several outcomes.

First, there was a general consensus that, on a *day-to-day basis*, it was important to pass on information. This level of communication on actions to be taken or decisions to be made about the patient, was considered adequate across all professionals. Whether by written

or face-to-face communication, professionals felt that they were responsive to and supportive of, each other's requests.

Second, the general patient orientation within the practice was made evident by the ambience pervading the workplace, with patients calling some professionals (not the GPs) by their first names, and professionals knowing details of, and enquiring after patients' families. An indicator of the relaxed approach which the practice encouraged was that reception staff cultivated a tolerant form of appointing, in which they did not generally quiz patients too closely on presenting problems (this did however mean that surgeries were very full on occasion, and the practice manager took steps at one meeting to tighten this form of gate-keeping). In addition to the fact that several staff and GPs had worked in this practice for many years, the patient population was also stable, which may have contributed to the building of this type of culture. There was evidence that the patients felt strongly that they had a good service from the practice in that they regularly brought gifts to the surgery.

Despite this approach to patients, there was not a considered 'team philosophy' of care, or practice strategies. Like the medical ward, individuals in this setting were too disparate to have developed a 'way of being' as a multiprofessional group.

It is not intended to imply from the comments in this section that all professionals should necessarily all hold the same views in terms of patient care or team management, but that they should be *prepared to negotiate* the issues and *respect each other's professional viewpoint*. From this could come a more cohesive approach incorporating or modifying different perspectives. If we think about the culture within the rehabilitation unit, where it was *expected* that feelings were expressed, discussed and managed, and where these were listened to and acknowledged, we can see how the development of a 'team culture' construed by all as 'safe' could help to overcome differences of opinion, and resentments. There, differing viewpoints were raised and discussed until a resolution was reached which suited all members. It was appreciated that dissension was the norm in terms of multiprofessional interaction, but that the way forward was open discussion in which all professionals' views were valid. Where there is no challenge to the *status quo* there can be stagnation, and where the *status quo* is dictated by only one professional group, that can lead to oppression. Neither of these options would seem to be helpful to the development of 'effective multiprofessional teamwork'.

6.4.2 How the leader influenced the team

Leadership as defined in the rehabilitation team related to one person who listened to others, was seen as responsive to, and facilitative of their ideas and opinions, and who actively reinforced the open and discursive culture of the team. Further, he promoted the development of the team in keeping with its stated philosophy of a problem-focused, multiprofessional approach to patient care, i.e. he *directed* the team in its practice, and helped to provide structures and processes which would make the philosophy manifest. However, he was also perceived as being a strong leader who could take unpopular decisions. This type of leadership has been identified as an important factor in effective mono- and multiprofessional teamworking (Tappen and Touhy, 1983; Goldenberg, 1990; Pearson and Spencer, 1995; Onyett et al., 1996).

Whilst this person wielded ascribed power, that is power situated in the role, it was also felt that he did so having earned credibility as a leader, that is, power situated in the person. This credibility as a leader, and through that a willingness on the part of other team members to follow direction, was not found in the other case studies. In the multiprofessional groups discussed in this chapter, the more common image was one where the most powerful team member assumed the lead in decision-making, but did not act as a leader. Alternatively, the most powerful team member assumed leadership, whether this was deemed appropriate or not. With both definitions, the power in the role was used to determine the decision-making process, rather than it being a 'team decision' facilitated by effective leadership.

Within the medical ward, the assumption by senior medical staff of clinical decision-making power, lay in the perpetuation of the 'medical model'. This was acknowledged by all professionals, and indeed where acute care was provided may have been most appropriate. Within the medical ward, the various consultants who visited, expected their decisions to be adhered to, but without necessarily having taken into account the input which other professionals would have seen as important. In effect the process was unilateral. This was often compounded by the manner in which senior medical staff communicated with other 'team' members.

In general terms, the professionals who commented most frequently about this issue were the nurses, but two PTs and one pharmacist also made comments about the *'closed attitudes'* of some consultants, which they felt disallowed their contribution. This could be translated into intimidating behaviour. One senior PT noted of a consultant that he frequently *'snapped the heads off'* her colleagues when they *'dared to suggest alternative ways of doing things'*. Other professionals' ability to deal effectively with senior doctors was also limited in this setting.

Intimidating behaviour was acknowledged to be seen in some *junior* doctors, a common statement being *'you can see what sort of consultant they are going to make when they first arrive, some of them are so arrogant'* (nurse). However, this tended to be dealt with in a more assertive manner by junior nurses as well as those with more experience of dealing with the medical profession. In this context the nurses appeared to match the SHOs' peremptory behaviour with a similar response, and indeed *'fighting fire with fire'* was also perceived by a few nurses to be the most appropriate strategy when dealing with senior medical staff. It was only observed however, in interactions between one male charge nurse and the consultants, and this nurse was 'used' by others to support their communication with the consultants. What effect did intimidatory communication style have on 'teamworking' and individual professionals? First it inhibited other professional input, limiting the development of 'team knowledge', and second it was perceived as undermining the value of others' roles in the 'team'. Both these issues were potentially detrimental to patient care.

In the medical ward rounds, required knowledge about the patient related specifically to their medical condition, rather than other factors which might impinge on that illness. The nurses for example, spoke about the way in which their assessment plans and the progress the patient was making in relation to those plans were not taken into account by consultants. It was perceived by the nurses and reinforced by observation, that the consultants' interest as far as nursing input was concerned, was the latest physical observations, and results of any medical investigations: in effect, information relating specifically to the diagnosis of the patient rather than to the patient as a whole.

This limiting approach often applied to the consultants' interaction with other professionals; it was largely an information-gathering process as defined by the consultant, rather than a discussion based on input deemed to be in keeping with other research (e.g. Busby and Gilchrist, 1992). Decisions about patient interventions were made on this basis; should other professionals disagree, it was not always easy to make their case. This is not to say that other professionals did not pursue their *own* plans for patient care in the consultants' absence, rather, that it was necessary to argue for the outcomes of that course being included in the decision-making process. For example, on several occasions, consultants were heard to make decisions about discharging a patient, and tell the patient, only for nurses to later explain to the patient that this was not possible for social, practical, or indeed physical reasons. Contradicting the consultant, face-to-face, was rarely seen.

It was perceived by some professionals that consultants' decisions did not reflect a holistic understanding of the patient. The nurses felt that the ongoing nature of their input gave *them* the opportunity to observe and act upon subtle changes; they also had an awareness of the psychological factors contributing to health. In combination this gave them an understanding of the patient's particular response to their illness, and how psychological factors

may have contributed to the illness in the first place. The nurses felt that this was not possible to achieve by those who simply visited the ward for short periods. It required an ongoing relationship with that patient; watching and listening to them. This knowledge however, was not perceived to be of concern to the consultants.

This limiting of 'team knowledge', and the manner in which it was done, was perceived as undermining the value of the nurses' (and others') role. Several nurses spoke about the specific and crucial aspect of *their* contribution, which they felt was not generally acknowledged. In all but one of the ward rounds observed, enquiries from the consultants or other medical staff did not include emotional issues, nor, seemingly, an awareness of external factors which may contribute to emotional problems and could affect physical healing. Enquiries related in general to physical symptoms and response to treatment. In the HDU some interaction between the nurses and consultants appeared to be more discursive, but on examination of the content, this related mainly to specific aspects of physical illness rather than consistently incorporating wider aspects of the patient's progress.

In general, the nurses accommodated much of the behaviour displayed by the doctors in a way which was not accorded to them (the nurses), i.e. they deferred to the vagaries of the use of medical power, thus reinforcing the lesser value attributed to them by senior medical staff. For example, in one ward round a junior nurse was with a consultant who was generally perceived to be very abrupt and dismissive of nurses' contribution. He would ask a question and not wait for the answer, or ask a question, then ask the same question of the SHO. The nurse later took the onus for the poor communication upon herself, saying that she had not expressed herself clearly. From observation, clarity was not the problem, forcefulness was. It was noted that, rather than deal with the consultant's autocratic behaviour, some nurses absented themselves from ward rounds, further limiting the potential to add to the body of knowledge about a particular patient, and thus influence decisions about that patient.

This section has shown that nurses and other professionals still needed to find ways of managing the emphasis on medical-led care, and by implication medical input into discussion and decisions about patient management. In addition, the assumption of medical power within the multiprofessional team and its effects on communication style, was perceived to be limiting to nurses' and other professionals' contributions to those discussions and decisions. This constituted autocracy, the wielding of power without the facilitation of other's input, to a supposed 'team' process of decision-making.

6.4.2.2 Decision making in the CMHTs

How was this approach to 'leadership' reflected in the CMHTs? Unfortunately, the transposing of the medical profession from the acute setting, where 'life and death' medical decisions may well necessarily reside with that profession, into the community, where this did not automatically apply, did not change the power imbalance; it did not affect the assumption of primacy in decision making to any large extent. Consultant 1 operated from an alternately 'hands-off' to a 'hands-on' approach, sometimes accommodating other professional input, sometimes making arbitrary clinical decisions. Overall, he wielded power without being a leader of the team, indeed he did not appear to want the position of 'team leader', rather he seemed to prefer only to preserve his professional autonomy. Consultant 2 *did* want to be the team leader, but despite his approachable, friendly manner, he consistently undermined other professional decisions, deeming them as inappropriate for clinical or resource reasons.

Meetings in which Consultant 1 operated, were extremely uncomfortable, and felt tense and oppressive due to the consultant's unpredictable behaviour, and memories of prior conflict between himself and other team members; team meetings were not considered a *'safe'* place to be. Interactions in these meetings were reminiscent of a ward round, where professionals spoke to the consultant rather than discussing cases together. As with many consultants in the medical ward case study, this professional's communication style could be very abrasive and

was perceived as dismissive, especially by the SWs. As suggested in the earlier section, SWs were however, ready to argue with the consultant, but without perceived agreed outcome.

Consultant 2 was rather different in so far as he had a clear idea of leadership; he wanted to lead his team in a specific multiprofessional approach where all professionals had an important part in the management of client care. Indeed, the model of CMH teamwork to which he aspired was underwritten by research (Onyett, 1996), and embodied in the *'team-developed'* document cited earlier (although this particular consultant was not in post at that time). However, his method of achieving this was through autocratic rather than democratic means. He expected multiprofessional attendance at meetings and complained if people did not attend. Furthermore he expected clinical discussion at those meetings. Yet, despite these espoused ideas about teamwork, he was renowned for making decisions on behalf of others, without prior discussion either with the professional or their clients.

For example he would inform clients that their CPN would no longer be visiting them, without discussing with the CPN either what was being done or why. This obviously created difficult situations when the CPNs arrived to see their clients for prearranged appointments. His response, when challenged about this, was that it was in the interests of team resources; he could see no conflict in his actions. For the CPNs, who were long used to operating independently as a referral point for the GPs, this was extremely frustrating and seen as undermining their professional autonomy. Not only did they believe they were they made to feel *'stupid'* in the eyes of their clients, but they were angry that their own programmes of care could so easily be overridden.

6.4.2.3 Decision-making in the PHCT

In the PHCT, issues of power over leadership were again seen. Except for one GP, this group of professionals saw themselves as central to the practice with their practice manager in a linchpin position between themselves and other people involved in the setting. This separateness was emphasised through the required use of the GP's role title while others were known by their first names. Two GPs saw this as a necessary distancing strategy.

Others in the multiprofessional group saw the GPs as a group of individualists who formed a controlling power base in the practice but took no part in leading the PHCT by promoting 'team practice'. For many other professional roles within the PHCT, such as the midwife, HV and DN, while they had some autonomy in their patient or client management, there was the growing expectation from their trusts that general strategies for action, such as protocols, would be followed to reduce ambiguous advice and information being given to patients, and ensure specific standards of care were adhered to. The GPs on the other hand had no such clear expectation of their treatment or the management of their practice. Indeed, they were perceived to have no particular direction for their practice at all. This left other professionals unsure of how to proceed over certain issues, and unclear of their role as part of the PHCT.

This issue was hindered further by the fact that the GPs did not facilitate 'whole team meetings'. Although the GPs had regular monthly meetings, and usually included the practice manager, these were to discuss the business aspect of the practice, rather than clinically-based agendas. It had been stated by the GPs that there were 'whole team meetings', but these did not include the HVs, DNs, or counsellors. The one such meeting which did take place in the course of the study included the practice nurse and the midwife, who *'were invited'* by the GPs. Commenting on the invitation of other professionals to a meeting would indicate not only the unusual nature of this behaviour, but also the fact that invitation was in the gift of the GPs, rather than being a 'given' that all professionals should attend.

The type of approach where arbitrary decisions about meetings were readily made, led to circumstances where, for example, it could be deemed appropriate for professionals to be dismissed from meetings in order for others to discuss clinical or business issues. Both the

practice manager and the practice nurse had experience of this. One commented that it was like *'being treated as a child'*, rather than a member of a 'multiprofessional team'.

From the evidence above it can be seen that none of the professionals who used their role power to influence 'team practice', did so from a position of *facilitative* leadership. *Leadership* would assume that a team or group was being taken in a specific direction, with or without agreement from the rest of the team; *effective leadership* could be premised on agreement and willingness to follow. *Facilitative, effective leadership* would assume team member parity, that all had an equally useful contribution to team knowledge and skills (as opposed to a reference to status or financial parity), not simply useful in the sense that they would 'do as they were told'. None of those who used their role power in these case studies offered either of the latter two definitions of leadership, and some did not even attempt the first. By the same token, none of the professionals in these groups had the sense of being in a cohesive team where one person was actively steering their practice in the direction they had chosen. Assuming one ascribes to the necessity for leadership at all, this would seem to be fundamental. Using role power to achieve decisions which may preclude important input from others is not.

6.4.3 Knowing how the professional roles contribute to the team

In the rehabilitation team, to a large extent, the structures and processes agreed by the team encouraged observation of, and learning about other professional roles. Through this process it was possible to develop a pool of team skills and knowledge which could be used to help create continuity and consistency of patient care. Many team members understood explicitly the rationale behind other team members' actions and understood the specific stresses and strains which each role imposed.

For the fragmented teams it was clear that organisational factors limited this level of role understanding. Within the group context, lack of role understanding was highlighted where new roles had been introduced, since either the roles were peripatetic, or a role had been introduced which subsumed two roles, i.e. to which they both contributed.

6.4.3.1 The specialist roles

In the medical ward two peripatetic nurse specialist roles had been created, one dealing with the discharge process, and one managing respiratory problems. The first role was supposed to encourage the co-ordination of discharge, with the specialist nurse ensuring that all professionals had completed their aspect of the process and informed others of their actions. The respiratory specialist provided education and advice for patients who had chronic problems which needed long-term management. The restrictive organisational environment had inhibited the ward nurses from understanding the nature of the new roles, and how they contributed to the process of patient care. Much of the enactment of these roles was hidden from the ward nurses; they saw the specialists arrive on the ward, but because of time constraints and other priorities, this was never a predetermined arrangement. As a result, the ward nurses were not always able to watch what the specialists did with the patients, leaving only what was written in the patient's notes, as communication.

This communication sometimes entailed changing a patient's intervention. Although the specialists endeavoured to find a nurse to inform of this, or even discuss it with them beforehand, this did not always happen. The nurses in the ward were wary of the new roles; they did not understand what the specialists did, how they did it, and how it fitted with what the nurses were doing. The specialists had made efforts to talk to staff about their roles, but this had not been done as a specific session, rather they had spoken on an *ad hoc* basis as they met staff on the ward.

As an outcome of this lack of understanding, some nurses became resentful of the specialists' input because they perceived the roles as encroaching on their own. Indeed, on some occasions, the activities of the specialists were explicitly interpreted as *'interference'*. With particular

reference to the respiratory specialist, the nurses felt that there was disruption of their own patient planning and on occasion this inhibited them from seeking this specialist's advice.

6.4.3.2 The keyworker role

Although in the CMHTs there was also the introduction of a new role, this posed different problems because it crossed two separate professional roles, rather than extending an existing role. Furthermore there had been changes to both these roles which had caused dissonance for both professional groups. In order to discuss the new role, it is necessary to set the scene by describing the changes to the roles.

In the case of the CPNs, their role had dealt largely with GP referrals of people with milder mental health problems. This had allowed them to engage in both therapeutic and health prevention work. Now they were required to manage clients with chronic and severe mental illness. This shift in emphasis required CPNs to look more broadly at the influence of social aspects of their clients' lives in order to offer the most appropriate care. Indeed, they may need to be involved in managing some of these aspects of care.

Many CPNs in this setting felt unprepared for this changed role and responded in one of two ways: by seeking training to enhance their skills and knowledge, or by standing firm and saying this was not the role they wanted to take. This latter group felt it would mean the loss of skills they had spent years acquiring; they saw that they had a monitoring and therapeutic role and did not want this encroached upon.

The traditional SW role had included managing the whole social aspect of client care, such as housing, unemployment and therapeutic intervention in terms of family therapy. Because of their statutory duties and their social focus, they had tended to deal with more severely mentally ill people, or those with chronic problems. The increase in statutory work and the reduction in their manpower now meant that aspects of their work, such as therapeutic intervention, was now not possible. As with the CPNs, some felt deskilled as a result.

The change of emphasis for the CMHTs, towards the more severely mentally ill meant that the roles of SW and CPN, to a larger extent, overlapped; the boundaries between 'social' and 'health' input had blurred. Because of the severity of mental illness, and the subsequent chaos that often created in housing and employment, clear divisions in client care were now inappropriate. It was difficult to untangle what was social and what was health. Did the lack of housing and employment lead to the mental illness or was it the other way around? Some CPNs acknowledged that their clients' main problem was maintaining housing, so that to define the nursing contribution to their care as only therapeutic or medical monitoring would have been insufficient. If a person did not have their basic needs met, what would be the impact of therapy?

The introduction of the keyworker role to the teams exacerbated this role blurring, partly because of difficulties in *determining who should take on that role* for any one client, and partly because of *differences in interpretation* of the role. First, given that there was now such overlap at their role boundaries, and the number of clients requiring this keyworker allocation usually required a complex psychosocial intervention, how were decisions made as to which professional group was allocated the case? Where there had been prior knowledge of, and working with a client by a particular professional, keyworking was relatively easy to assign. The problem came when the person was not known to the CMHTs. In these situations there was a general perceived unwillingness for either group to take on the role: the CPNs felt unprepared to deal with the complexities of the cases, and the SWs were over-committed in dealing with statutory obligations.

Second, in terms of interpretation of the role, the health professionals understood that it required that each client was allocated a specific professional who would be responsible for the co-ordination of their care. This could be any professional within the team, but those

who were more severely ill were allocated a CPN or a SW because of the frequency with which they would need to be seen. The CPNs' understanding of this role was that the keyworker would need to be *aware* of all social interventions in order to *co-ordinate* the care, however, they would not be responsible for *actioning* the interventions.

However, the SWs had a different understanding of the role related to their service's previous practice. The SWs had for some time been involved in case-management. This meant that an identified case manager would be responsible for not only co-ordinating aspects of a client's care plan, but also executing all aspects of that care plan. It was this interpretation of keyworking which the SWs ascribed to. As this case management aspect of their work developed, dealing with housing issues had come to be seen by health professionals as a fundamental aspect of the SW role.

With the keyworker role now being for any CMHT member, the SWs assumed that the CPNs would not only include more social awareness in their thinking, but also take on a social aspect to their work; this did not readily occur. The CPNs argued that they had neither the time nor the skills, as a keyworker, to manage all aspects of client care. They argued that the SWs had smaller caseloads which allowed them to pursue housing or financial problems thoroughly. The SWs, were unhappy that they should still be required to take on the main burden of housing or employment problems, and felt that changes in the CPN role should have prepared them for wider activities with their clients. Reinforced by the reduction in their numbers, they began to decline to take on housing and financial problems when referred by the CPNs.

As a result of this role confusion, many CPNs felt that, since the SWs were not doing what the CPNs saw as their role, they did not now understand what the SWs *were* offering to the team. By the same token, several SWs felt that the CPNs were being professionally *'precious'* by adhering to their *'old role'*. They understood that CPNs might need guidance and assistance in the more complex cases, but still they felt that this was appropriate for *members of a CMHT*. Since there was little active support from either professional groups' management in resolving this issue, team members became entrenched in unhelpful positions. Far from being a mechanism for including and co-ordinating team members' activities with a client as a 'team' process, the keyworker role was used to reinforce the professional role boundaries further (this problem is corroborated by Simpson, 1998).

6.4.3.3 The effects of role change for teamworking

As was also seen in the medical ward, new roles were perceived to have encouraged professional defensiveness, and as a result, exacerbated monoprofessional stances. However, in this context, the role boundary dissension sprung from different sources and created different responses from those involved. In the medical ward, the new roles were an extension of nursing, that is, adding to a body of knowledge; in the CMHTs, the role crossed two different bodies of knowledge.

Some nurses who were visited by the peripatetic nurse specialists saw the specialists as *'nurses and a bit'*, not understanding the specific educative role which the respiratory nurse specialist, in particular, had developed. The specialist was still seen as operating from the nursing body of knowledge rather than having her own from which others could benefit. In some ways she was still seen as a *'doer'*, not an educator. Thus it was difficult for the nurses to feel they could learn from her; if they needed additional advice or knowledge, they would go *'to others'*. The implication seemed to be that:

- there was a boundary to nursing knowledge which encompassed the specialist
- the specialist nurse had transgressed that boundary.

The organisational environment had limited the nurses from seeing the nurse specialist's 'role in action', and had detrimental outcomes for the nurses as a professional group. The nurse specialist was perceived with ambivalence; was she of the nursing profession, or not?

Until the nurses had the opportunity to develop an understanding of her role, the specificity of her knowledge and how that could enhance the nurses' practice on the ward would not be acknowledged.

In the CMHTs, rather than needing to redefine the new role as 'other', as in seeing the nurse specialist role as different from the nursing role, the new role needed to be *incorporated* into the 'nursing' role. However, the keyworker role was *'the ball which nobody wanted to catch'*. All CPNs protested that it did not come within their body of knowledge; it was not 'nursing'. Some *were* prepared to develop their role but needed training to meet the new demands. In general however, the CPNs did not want to be *'pseudo SWs'*. Their nursing role was specifically therapeutic and they did not want to risk losing the specialist knowledge and skills. They feared that if they took on the keyworker role they would not have time to manage both aspects comprehensively. For some CPNs, taking on this social aspect would challenge their definition of themselves as therapists, and one senses a hierarchical nature to the appreciation of their body of knowledge in comparison to that of the SWs.

The SWs could not accept the CPNs' limited definition of nursing. They felt that CMHT members should expect to address all aspects of care, more in keeping with a generic interpretation of being a team member. They appreciated that there would be areas of specialist knowledge for each profession, *'medical knowledge'* for CPNs and statutory work for SWs, but saw the overlap as much wider than the CPNs. Given the reality of the similarity of the CPN and SW roles within the new focus of the CMHTs, the SWs' views seemed more appropriate.

The issue of role change and its ramifications for education (in its broadest sense) was acknowledged, but not addressed by relevant professionals during the course of the studies. Given that fluidity of role seems an inherent part of the current NHS, it would seem important that students learn to appreciate its impact for their own definition as a professional. In the rehabilitation setting, many team members had developed their roles to include new knowledge and skills, and this had been achieved to a large extent without professional defensive behaviour. There were several reasons why this may have occurred so readily: managerial support, resource stability, a culture where it was considered safe to learn, an environment where professionals could watch others in action, and forums to debate changes in team practice. In all, given the context, one could argue that moving role boundaries would be unlikely to prove difficult in this environment (excepting the difficulties for the nurses). In the fragmented multiprofessional groups few of these factors were present. Therefore, while education (in the narrower meaning) could help students to develop an understanding of greater role flexibility, it would require support for that approach to continue into team practice, both with organisational and team input.

6.4.4 Becoming a new team member

The final issue explored in this section is the integration of new members into such fragmented 'teams'. In terms of the medical ward and the PHCT, this was not an identifiable process; people operated at such a distance from each other professionally that integration was a meaningless concept in multiprofessional terms. For the CMHTs, because of their geographical proximity, and the fact that they had developed some of the symbols of 'teamworking', for example meetings as a team, integration was an issue, albeit a negative one.

Just prior to, and in the course of the study, there were several new members to the CMHTs, two were permanent staff and two were students on three-month placements. Although it might be expected, from the transient nature of the students' position in the teams, that they would not feel a sense of belonging, in fact *none* of the newcomers found it easy to feel part of the team. The new CPN said she was *'floundering'* having been in the team for three months, and the new OT felt isolated. The reasons for their negative feelings had similarities and differences.

For the CPN it could have been supposed that she would have been welcomed as a fellow professional by other CPNs, and shown the *'way it is done'*. She attended CPN meetings in which she would have learned about the structures and processes *for the CPNs in the team*. The OT was one on her own, so that she had no peer group to tell her what it was like to be an OT in the 'team'. However, both these new professionals found it hard to learn about other professionals' structures and processes, since they were largely hidden from view.

During the course of the study, other than ward rounds (and these were rarely multiprofessional), there was no way in which others' professional practice could be observed. Weekly team meetings, in one CMHT in particular, were seen by new professionals to be unproductive due to the lack of facilitative structure; the rationale for the inclusion of specific clients for discussion was hard to fathom. As a result it was difficult for newcomers to know how or when to raise relevant issues. Both the CPN and the OT were commonly heard to ask, after the meetings, when they could, or should, have said or asked something. They felt they *could not raise these issues* in team meetings, such was the nature of the climate.

The OT had come from a team where she felt there was a team decision-making process; referral, and allocation were decided as a team, and the structure of the weekly meetings was designed to incorporate all aspects of a client's progress. For example, she stated that new referral and allocations would be commented on, assessments fed back, joint action discussed, and case review with the outcomes of client progress to measure against being a regular part of the process. Although some of these processes were included in one of the team's meetings, neither CMHT had such a comprehensive team approach. As a result, the OT in particular had little way of compiling a picture of how the team worked; she therefore found it difficult to prioritise her work and felt that people only came to her with clients when they could not think how else to proceed. In effect she felt as if she was a *'last resort'*, rather than an integral part of the team. Because of this emphasis on her work, she felt that she was unable to demonstrate the range of her skills and knowledge. In the rehabilitation team, the nature of team practice ensured that new professionals learned the process of patient care quickly, and how they could contribute to it, while it also gave them opportunities to show, comprehensively, how effective that contribution could be. In these ways becoming a team member was facilitated by the team.

Towards the end of the CMHT case study, both new professionals had accepted the fact that there were no 'teams' to belong to, in the sense that there were two groups of people moving in the same direction with a uniting purpose. This was particularly frustrating since both come from more welcoming and readily integrating teams. The mismatch between the beliefs the OT had developed from her prior experience, and the reality of her current experience will be addressed in Section 6.5, which examines how individual philosophies of teamwork can shape team function.

From the discussion in this section relating to beliefs and values, power and leadership, role boundaries, and becoming a team member, what and how do we need to teach students and existing team members about these aspects of being a multiprofessional team member?

6.4.5 Learning implications

- *Team structures should promote multiprofessional working*, rather than maintaining monoprofessional systems.
- Within those structures, a *process needs to be developed which supports equal professional input* related to specific client pathways of care.
- *Role clarity* is important in order to promote team cohesion, and role confidence, but an understanding of the benefits of *flexibility of role boundaries* is vital for their professional development. To develop their own skills and knowledge through learning from other professionals helps to foster team knowledge, and creates closer working relationships.

- An *unsafe environment can inhibit this equal professional input.* In this case strategies would need to be found which would assist in overcoming this situation.
- *Powerful roles within a team can undermine other's role value in the team.* Communicating consistently and assertively in order to have a voice in the team is a vital skill to learn.
- Ways of *integrating into groups* should be developed which take account of the fact that these may not be looking outward to include others. Existing team members need to explore *how to help new members into a team* by allowing new members a voice, encouraging demonstration of skills and knowledge and providing a social forum for them to become acquainted with the team.

The final part of this chapter looks at the way in which team members may hold different understandings of what multiprofessional teamwork means, how that may affect team function, and what it will mean for other professionals in that team.

6.5 The individual's influence on multiprofessional working

Chapter 5 examined a multiprofessional group which largely shared an approach to working, i.e. they were a team. The majority of professionals were aware of the benefits of multiprofessional working, and could see the same factors as important to make the group function in a such a collaborative fashion. This shared understanding was perceived to promote 'effective' multiprofessional teamwork. The philosophies of multiprofessional working held by those who did not 'fit in' with this approach were discussed. One newcomer had views which opposed the existing team's ideas, and some nurses were slightly removed from the main body of the team because role uncertainty constrained them from participating in the same manner as others. Having examined the differences in understanding about what constituted 'multiprofessional teamwork', three approaches to multiprofessional teamworking were proposed; *integrative, elective* and *directive.* This section again addresses individuals' perceptions of teamwork, and re-examines the approaches in the light of this further evidence.

The three groups discussed in this chapter were very different in terms of the extent to which professionals shared views about multiprofessional teamwork. The professionals in the medical ward to some extent acquiesced to a traditional hierarchical, but undeveloped view. Members of the CMHTs and the PHCT held more developed but widely differing views. For this reason they are initially discussed separately.

6.5.1 The traditional approach

To the extent to which it could be determined at all, within the medical ward a large number of professionals held a similar view of teamworking: that one group, the medical profession, held the power in the decision-making process, and other professionals acquiesced and/or supported those decisions by *working to* the medical profession. Basically this was a 'do what I say' or *directive* approach to multiprofessional working. (This is not to say that all other professionals were necessarily satisfied, but it was accepted that the *status quo* would be hard to change). However, it was not the *status quo* of the *directive* approach that was most troubling the medical ward group, but the organisational fragmentation. Few spoke about 'multiprofessional teamworking', they had too many problems in existing from day to day, managing patient care as best they could under difficult conditions.

Those who were more experienced had fond memories of the more traditional variant of the *directive* approach and praised it for its effectiveness in terms of clarity of communication and role. They related images of the small ward where one or two consultants and other professionals made regular visits and time would be made by the ward sister to be with those professionals. She (for it was usually a she) would manage ward rounds, having gathered all the available information from the nursing team.

This professional would be seen as a role model for her nurses, would advise junior doctors, and offer opinion as well as information to the consultant. However, the consultant would make the decisions about treatment and, in many cases, care. In this understanding of multiprofessional teamwork everyone *'knew their place'*. The consultant would expect that what he or she ordered would be done, for example that nurses would carry out the tasks required for a specific patient programme, in the manner determined by the consultant. As such, it was perceived that the ward ran smoothly with patients enjoying continuity and consistency of care.

Furthermore, it was perceived that among the permanent ward staff and medical and therapeutic staff, stability and predictability meant that the various professionals were able to develop an understanding of each others' strengths and weaknesses, as people and as professionals. Was this an accurate reflection of those times? Whether or not, it does indicate that congruence of an understanding of multiprofessional working is perceived to facilitate 'effective' teamwork in the sense that it operates smoothly. However, it does not say anything about the team's effect on patient outcomes.

Although the structures and processes which supported this approach to multiprofessional working had to a large extent disappeared, the traditional perceptions of multiprofessional interaction remained as an interweaving thread which governed the way in which professionals operated.

A few professionals in the medical ward team, a male E grade nurse, a German SHO, and to some extent nurses in the HDU, expressed views of teamwork which differed from the prevailing view. However, their lack of numbers and status would have made it difficult to elicit change. Further, since they only commented on certain aspects of multiprofessional teamwork, rather than holding a more unified set of beliefs, it was hard to determine whether their ideas actually contravened the prevailing view.

The male nurse seemed to hold views related to a greater degree of parity of professional input. He perceived that the consultants' communication style limited ward nurse communication, providing other professionals with only a partial picture of the patient. He had come into nursing from industry as a mature student, and had several years experience as an E grade nurse. He had firm beliefs about the nurse's role as patient advocate which encouraged him to challenge the decisions made by some consultants. For example he was observed on several occasions to question decisions during ward rounds, in particular related to discharge timing. His challenge was based on his knowledge of problems with the patient's social situation, which needed to be pointed out to the consultant. He felt that speaking out would alert the consultant to the current situation but might encourage him/her to consider these aspects on another occasion. He commented that other nurses may well have accepted the decision, then had to manoeuvre other professionals later in order to comply with the consultant, or have kept the patient in until the discharge could be managed. Either way, the patient would have been confused at the change of events.

The nurse associated his success in communicating with the consultants with the fact that he *'played the consultants at their own game'*, he matched their assumed air of authority. He noted that some nurses had a problem with the consultants, their unwillingness to voice their opinions in a fashion consistent with those in positions of power compounded the communication difficulties in this setting. He commented that he talked to less experienced nurses about this issue and tried to raise their awareness of the need to challenge the consultants. However, his success in acting as a role model for others seemed limited, since there was evidence that this nurse was 'used' by others on several occasions to obtain information from or to challenge 'difficult' consultants. He acknowledged that his gender and age may have been influential in these situations.

The nurses in the HDU however, shared the male nurse's belief in voicing their opinions and frequently used opportunities to comment on patients' physical, psychological

and social progress (although the emphasis of their input tended to relate to physical progress). However, it did not seem that the confidence with which the nurses expressed their opinions was based on perceptions of an egalitarian view of multiprofessional teamwork; rather they felt that within the system, it was important that they *should* express *'the nursing knowledge'*. It appeared that they wanted to give a broad picture of the patient, in the understanding that this was within the framework of a *directive* approach to decision-making.

Some younger senior medical staff were aware of the need for multiprofessional teamworking, but it was clear that they would direct the 'team', that is it would be *theirs*. This view of teamwork depended on the persistence of a medical model of working, where diagnosis steered the treatment and care given. The discussion in the previous section illustrated how the doctors still heavily influenced other professionals' actions, rather than those professionals bringing their own specific body of knowledge which may or may not have coincided with the perspective of the doctors, and so have altered the pathway of care.

One registrar epitomised this multiprofessional 'team director' approach. He would come to the ward and discuss specific cases with nurses and other professionals in order to compile as comprehensive a picture as he could of the patient. He would show role flexibility by offering to help nurses if they were busy, and was observed to assist in getting a patient off a commode and into bed. As a result he was extremely well thought of by the nurses. However, his beliefs belied his actions, bringing into doubt their underlying motive. He believed that other professionals worked to him; that with a wide picture of the patient *he* could make decisions about treatment. His assumption was that he would be *'in control of the team'*, but of a team in which he valued other professional input. Value in this sense seemed to relate to the *tasks which others performed* within the 'team', for example, the proficiency of the nurses in the HDU in monitoring oxygen saturation levels and adjusting oxygen input accordingly. Value did not seem to be related to the body of knowledge which might inform other professionals' judgements and actions. This was evident in that he did not show an awareness that he could learn from other professionals; in those terms he perceived that he learned from his peers or seniors.

A final aspect of his and other senior medical staffs' beliefs about multiprofessional working was that others would accommodate difficult behaviour. As suggested above, several consultants exhibited abrupt, abrasive, or downright rude behaviour. The registrar described above seemed no different in his assumptions, from observations made in the ward and subsequent comments by nurses. They felt that they *'just put up with that and keep out of their way'*.

In this context, other than the male nurse's response, it was accepted that other professionals needed to learn how to cope with those behaviours rather than challenge the situation. It was common for experienced nurses and other professionals to rebuke very junior doctors if they showed this type of behaviour. However, such was the pervading influence of the medical culture within which the junior doctors were embedded, that these early learning experiences did not appear to last. Some nurses commented on this in watching the new doctors progress and change to match their medical environment. In Chapter 7, it will be demonstrated that these beliefs about teamwork were not necessarily culturally acquired, that is, not all those from the medical profession ascribed to them. Where they were absent, it seemed to be possible for a more egalitarian approach to multiprofessional teamworking to develop.

The way in which the doctors' beliefs about multiprofessional working influenced other professionals, particularly with relation to task value, may help to explain the problems of the nurses in the rehabilitation unit. In their difficulties in defining their skills and knowledge as equals, it seemed that the legacy of working in an environment where this set of beliefs would be prevalent played a part in hampering their professional confidence. Unlike the HDU, the rehabilitation setting lacked the highly technical skills which may have helped the nurses to gain confidence as professionals. The double impact of being unable to express professional prowess through skills demonstration rather then knowledge sharing, *and* of having been

nursing, seem likely to have created problems of role uncertainty.

6.5.2 Differences in concepts of multiprofessional teamwork

In the CMHTs and the PHCT there was greater disparity between the views of the various professional groups, and within the professional groups.

In the CMHTs, most of the SWs and the OT had ideas about multiprofessional teamwork which included the concept of parity of input, challenge to the *status quo*, an understanding of the way in which structures and process could facilitate multiprofessional teamwork, and a belief in role flexibility. However, overarching these ideas, was a commitment to a concept of multiprofessional teamwork. These views were similar to that expressed by many members of the rehabilitation team, identified as an *integrative* approach.

Many of the CPNs, and Consultant 1 to some extent, shared a view which was far more monoprofessionally-oriented, and in which professional autonomy was a powerful driver; they believed that in many ways, they should be self-governing rather than team directed. This resulted in practice which 'elected' when and what to communicate to others and appreciated clear firm role boundaries. Consultant 2 had a view of teamwork which matched that of the medical profession in the medical ward setting; he was the leader of his team, and therefore could direct others' practice. He, like younger medical staff in the medical ward, was committed to the concept of multiprofessional teamworking.

Like the SWs and the OT in the CMHTs, there was a group of professionals in the PHCT who shared similar ideas related to an *integrative* approach to multiprofessional teamwork. The HV, midwife, practice nurse and practice manager felt strongly that the 'team' needed developing as described above, in order to function more effectively. One of the GPs supported many of their beliefs, but did not speak out as forcefully about how change could be achieved. Perhaps as a junior and part-time partner in the practice she was loath to criticise the *status quo*.

The other GPs and the DNs held views that matched the beliefs of those in the medical ward; they subscribed to an undeveloped *directive* approach to multiprofessional teamwork. There was not a perception of proactive leadership, simply the use of medical power to request action was accepted as appropriate.

Not surprisingly, given the number of professionals who held different views, and the power base from which some professionals promoted their views of teamwork, clashes in the CMHTs and the PHCT were more obviously exhibited than in the medical ward setting. It was seen that there were mismatches in *team awareness, communication, and role expectations*.

6.5.2.1 Mismatches of team awareness

From the way in which they spoke and acted in various multiprofessional settings, it was clear that the SWs, Consultant 2, and the OT in the CMHT, and the HV, midwife, practice nurse, GP and practice manager in the PHCT shared an awareness of the importance of working in a multiprofessional team. They appreciated that this demanded effort on two levels: the development of a social underpinning to professional interaction, and a willingness to develop cohesive professional relationships in a multiprofessional context.

For example, in the CMHTs, some team members moved during the course of the study. The SWs and the OT were the only professionals who raised the issue of a social event to mark the occasion, and made the necessary arrangements. Consultant 2 'played the host' at the event and helped to clear the debris afterwards. All these professionals were also prepared to make time to discuss clinical issues, including those not directly related to their own practice. Furthermore, the SWs and the OT understood how allowing others to see their anxieties and distress relating to certain clients, encouraged supportive behaviour from other professionals, and so strengthened a sense of belonging in the team.

By contrast, most of the CPNs displayed less willingness to develop 'teamness', and some CPNs and Consultant 1 showed little, if any, motivation to become a part of the wider multiprofessional team. The latter group displayed some of the beliefs about teamwork expressed by the newcomer in the rehabilitation team. One of these was that their time was limited, and should be devoted to their clinical responsibilities, not meetings. Another was that team members should have clearly-defined, impermeable role boundaries. Attempts to alter those boundaries would be rejected. In short, they did not seem prepared to make the effort to develop closer multiprofessional working. One of the reasons for this was that they placed great store by their professional autonomy. This belief in self-governing, rather than being steered by team influence, supported their lack of willingness to be multiprofessional team members.

Those who held these beliefs spoke about their *own* interventions with patients as being of great importance, rather than the *team's* interventions. Since 'team interventions' were not a reality in this setting, this may seem a pointless statement, however, the SWs, the OT and Consultant 2 spoke at length about what they would *like* to achieve clinically, as a team; they could see the benefits this would bring and therefore would be prepared to strive to achieve this situation. Where other professionals were not in accord with this level of enthusiasm however, it was perceived as difficult to change the *status quo*.

For 'team-minded' members of the PHCT, their interviews and general conversations were rich in allusions to sharing knowledge, sharing similar approaches to care, and an awareness of the necessity of 'building' a team, rather than assuming it would simply happen. They had all endeavoured to promote the development of regular discussion and debate. Between them (although not all together), meetings were suggested and arranged which had helped to promote closer working relationships.

For example the midwife and the HV had seen the need for better co-ordination at ground level in order to improve antenatal and postnatal services. Previously they had not seen each other regularly, and the HVs did not always receive antenatal bookings. The aim had been to establish a forum where they could discuss clients, and problems they were having with communication. As a development of these discussions they established new protocols for breastfeeding and for identifying clients at risk, and improved the notification system. Both felt that these meetings had helped them to determine the nature of each other's contribution to the antenatal process, and their handover process. Furthermore it had established an alliance between two trusts' practice, the mismatch of which had been of concern to them both.

Others in the PHCT did not share these professionals' enthusiasm for collaboration, which greatly hampered the fostering of their point of view. Although all the GPs were perceived to be friendly and approachable, they did not use the same language to describe their interprofessional interaction as was heard from the team-minded professionals. Nor was their behaviour as facilitative of 'teamwork.' In fact some were perceived to act in ways which precluded an awareness of other professionals' reactions. For example one GP would cancel his clinics at short notice, leaving reception staff to contact patients, and people such as HVs and the practice nurse to attempt to rearrange their own appointments with patients who would have been seen by the doctor.

6.5.2.2 Mismatch of communication

What was considered effective communication also differed as a result of holding specific views about teamwork. In the CMHTs and the PHCT, those who were 'team-minded' all felt that communication should relate to different aspects of multiprofessional teamworking, and that it should be on several levels, the first of which was clinical communication. Within that there should be both information sharing, and discussion on a multiprofessional basis where relevant information should be pieced together so that decisions could be made.

First, team-minded professionals recognised the limiting nature of communication which was simply receiving directives, or information from others. In the PHCT, for example,

one HV was concerned at the single line referrals she was getting from one of the GPs, as in *'please weigh this three-year-old child'*. She wanted to know why she had to weigh the child, what were the problems, what was the GP expecting to find out; any number of issues which she felt should have been discussed.

Second, many team-minded professionals could see the importance of having time to discuss team practice; which should include what the team was doing now, where it wanted to go, and how that should be achieved. They recognised that this aspect of teamwork was rarely pursued since it was not clinically related and others might see it as *'wasting precious time'*. However, it was felt that without such communication a team could 'drift', with no clear understanding of its purpose and direction. They also recognised that because 'why' questions could be asked in this forum, professionals could develop a better understanding of each other's contribution, and how the various roles fitted together or overlap, and whether there were better ways of 'using' various professional input. In both multiprofessional group settings, the team-minded professionals had endeavoured to encourage this type of meeting, with little success.

Third, social communication was important for the team-minded professionals. They realised that teamwork does not simply happen; it needs sustained effort. In the CMHTs, the 'good-bye' gatherings were a good example of this effort. In the PHCT similar attention to social interaction was seen among the team-minded professionals. For example, they suggested and organised a Christmas dinner to which *all* team members were invited. In previous years the GPs had taken the reception staff, the practice manager and the practice nurse out for a meal, by implication not acknowledging the input of other professionals contributing to the care of their patients. Such lack of acknowledgement was an important issue for the team-minded since they perceived that it carried with it a whole raft of assumptions about their value in the multiprofessional context.

In relation to a specific aspect of their role, the influence of their professional knowledge, one of the 'team-minded' professionals differed. In the CMHTs, Consultant 2 had difficulty accepting challenges to his opinions and decisions. The way in which the SWs and OT discussed cases included proposing ideas and opinions based on their professional knowledge, in recognition of the fact that this could sway decisions about programmes of treatment. Inherent in this was the concept that *challenge was appropriate*. Each acknowledged and respected others' input as of equal importance to their own, but expected to challenge others, and for this challenge to be given weight. They saw this as fundamental to the development of the team, that it needed to be dynamic.

By comparison, although the SWs and the OT expressed their knowledge and opinions, Consultant 2 used dismissive techniques to enable *his own views* to lead to *his* decisions. While seeming to encourage challenge, he manoeuvred the situation to deflate it. Thus, despite operating differently from many of the consultants, he achieved the same outcome; he gathered the information, then he made the decision.

What did other members of the multiprofessional groups believe about communication? In the CMHT, some CPNs were more discursive than others, but in general they were a group who worked alone and *liaised* with others. This they seemed to do efficiently, ensuring they left notes for relevant professionals if necessary. Although many attended meetings regularly, they often agitated for discussion to end and the meeting to 'move on'. Discussion of team practice was not generally popular with them; their own practice was more important. Indeed, their overriding concern seemed to be with their clients. (This is not a negative value judgement, all professionals could be expected to be more concerned about their clients than team membership; however, this group attached *little* importance team membership).

This monoprofessionally patient-centred approach was echoed by Consultant 1. The lack of discussion and challenge to the *status quo* resulted in a climate of *'stagnation'* in this team which was noted by several professionals. Because the climate of the teams was in general, influenced heavily by the consultants, Consultant 1's approach to communication prevailed.

In the PHCT, professionals such as the senior GPs and DNs interpreted effective communication as passing on information rather than sharing ideas about patient management. Furthermore, the GPs were perceived to control the flow of communication. Requests made to them could be blocked without explanation, and challenge was effectively quashed. For example in one meeting to which the practice nurse and practice manager were invited, the latter raised an item on the agenda regarding locum cover. One of the senior GPs said that the GPs would discuss the subject between themselves; this was agreed by the second senior partner. However, one team-minded GP said she was happy for her views to be known, and supported the idea of providing locum cover. The senior partner maintained his initial stance, effectively inhibiting the junior partner's input and disallowing further discussion.

The differences in communication between the various professionals made it frustrating for all. Many team-minded professionals believed that detailed communication enhanced their practice, and benefited the client. In the CMHT, where the SWs and OT came into contact with Consultant 2, they felt listened to but not acknowledged, undermining their professional judgement; with many of the CPNs and Consultant 1, they felt inhibited from sharing more than information about clients.

For team-minded professionals in the PHCT, interaction with most of the GPs resulted in communication which denied their knowledge and experience, and deterred them from sharing any understanding of where or how the GPs saw the practice developing. Particularly for the practice nurse and HVs this was a major frustration since both could have been involved in the development of proactive health work with targeted population groups.

6.5.2.3 Mismatch of role expectations

As will be seen in this discussion of the keyworker role, and the description of the discrepancy between the practice manager's understanding of her role and the GPs' definition, there were very different role expectations between members of these multiprofessional groups.

In the CMHT for example, expectations related to role flexibility which the SWs wanted of the CPNs. This reflected the complex nature of mental illness which encompassed the problems of those with 'antisocial' behaviour living in the community and finding it hard to maintain accommodation and work placements. As with members of the rehabilitation team, many SWs believed that teamwork should include willingness to extend skills and knowledge to provide better continuity, and that the skills required by *all team members* should include addressing social aspects of care. For experienced SWs, monitoring the effects of certain drug regimens (traditionally a CPN role) could be included in their role.

Because of their approach to multiprofessional working, implicit in this belief about roles was that extension of skills and knowledge should involve shared learning. This was defined by some people as simply one professional learning from another, but like many members of the rehabilitation team the SWs saw this as a reciprocal venture; they and the CPNs would learn from each other and form a 'safety net' for clients, by linking their professional roles. This did not mean the SWs were necessarily advocating the introduction of a generic mental health worker, rather they saw the need for greater role flexibility outside their specialist knowledge and skills.

None of the CPNs talked in this fashion, and some, by contrast, felt their own role should be preserved. They did not feel it appropriate to move away from their 'nursing role' of therapy and monitoring the effects of medication. This partly related to resistance to change. Many CPNs had invested time and energy into developing their skills and did not want to dilute these by involvement in social intervention. However, it also related to a belief that multiprofessional working was about maintaining tight role boundaries, where each professional was clear in what they contributed to the team. Certainly all CPNs in the study were clear about their role, but many also knew what they did not want it to be.

The OT in the CMHTs took a broader approach to her role, believing it should encompass the initial process as part of a multiprofessional assessment and care plan development, rather than being referred to by other professionals as they saw fit. She had come from a team where her role was fluid, where she was involved from the initial team referral to team assessment, monitoring clients' illness and drug regimen; even to the extent of taking part in the sectioning process. Like the SWs she saw that this approach benefited clients, while keeping sight of her own contribution as an OT.

The earlier discussion on role boundaries made clear how different perceptions on role could lead to professional defensiveness. The protection of roles became problematic for clients as was exemplified in one team meeting where a person had been assessed in the day hospital by a nurse. She had identified that he needed a keyworker to take on negotiation of his accommodation and funding; suggesting this in the meeting she was faced with silence from the CPNs. The nurse came away from the meeting feeling unsupported, but above all disturbed that the client had not been dealt with by those in the meeting. Professional role protection seemed to override patient focus. This mismatching of role expectations was fundamental to team dysfunction and arose specifically out of different perceptions of multiprofessional teamworking.

In the PHCT, the mismatch between team-minded professionals and some GPs, in terms of role expectations created great conflict. For example during the case study the practice manager resigned after a long 'battle' in which she had felt undermined. She had come from a practice where she had a position of *'respected partnership'* with the GPs. She spoke about regular meetings with them and other members of the PHCT, where team strategies would be developed. Furthermore, she was expected to devise and explicate business plans with the GPs. Her perception of her position in this setting was very different.

She felt disempowered because the GPs *'hold the reins so tightly'* and *'keep me in the dark'*. Evidence of this was observed related to the employment of a new counsellor. The manager had not been involved in interviewing for this post or received much feedback other than someone *had* been appointed. In a meeting with the GPs she pointed out that she had been unable to draw up a contract for the new counsellor since she had no information about the basis on which she was being employed; this was not acknowledged by the senior partners.

She believed that the GPs in the current practice saw her role as an administrator, in a position between themselves and practice staff and simply carrying out whatever tasks were delegated to her. Interview and observational data reinforced this perception and provided evidence of similar mismatches in terms of most of the GPs and their perceptions of the practice nurse, the HVs and the midwife. In all these cases there was a belief that the GPs delegated tasks, rather than other professionals having intrinsic value for their contribution to the PHCT.

For example, the practice nurse had been involved setting up a computer system in her previous post, whereby patients could be tagged for specific aspects of their management. She recognised that patient groups could then be targeted for specific preventative intervention such as running a clinic for people who were overweight. She had suggested this system to the GPs who were not prepared to listen. They saw her role as dictated by them and defined her work simply as responding to the outcome of their interaction with patients, taking blood, weighing, and immunisation.

This reactive working compromises the extent of other professional input. Furthermore, lack of acknowledgement of the wider aspects of other's roles has been linked with lack of willingness to learn from them. This was evident in interviews with most of the GPs, and like their counterparts in the medical ward, learning from others related to their peers or those more senior to themselves.

This section has demonstrated there were generally shared perceptions of multiprofessional working in the medical ward setting, and the very different perceptions in the

CMHTs and PHCT. While some professionals in the medical setting exhibited aspects of other ways of thinking, for example the male nurse and his views on communication, no one professional had developed an understanding of multiprofessional teamwork based on a different rationale from the *directive* approach. Within this view, an understanding of leadership differs from that in the rehabilitation team.

The *directive* approach is predicated on role power, and assumes that one person makes the decisions, not only with regard to their own specific input, but also to others' contribution. It depends on others deferring to those decisions; challenge is perceived as uncomfortable for those concerned. The approach precludes parity of input, in the following terms: depth of communication, sharing knowledge and skills, and role valuing.

Some who operate this approach as the directors rather than directees, may range from the autocratic to the apparently more democratic, however, in the course of this research, the fundamental point of differentiation was that directees' input was seen as important in terms of how it served the decisions of the director, rather than for its inherent importance. The examples of Consultant 2 in the CMHT, the senior GP in the PHCT, and the registrar in the medical ward exemplify this point. Other professional bodies of knowledge seemed to be subsumed by the overarching importance of medical knowledge, since doctors went to other medical professionals for advice and guidance. This extended even to such topics as teamwork; that is, how to *run a team* rather than how to be *a team member*.

For others working within this framework, their role would be valuable for the *tasks* it provided rather than for their role *perspective*. Value lay in what was done, rather than why. This is epitomised in the 'handmaiden' perception of the nursing role, unfortunately still prevalent in several of the settings in this study.

In the CMHTs and the PHCT most of the team-minded professionals operated from a perspective where *integrative* practice was seen to be the most effective way of working multiprofessionally. They were aware of the need to attend to team processes, reflect on their practice, share their opinions and experience, challenge others and expect to be challenged, be prepared to be fluid about their role boundaries, and in so doing to learn skills and knowledge from others. They expected to be valued equally within a multiprofessional team context. There were clear similarities between their perceptions of multiprofessional teamwork and those of many members of the rehabilitation team.

In the CMHTs, while some CPNs had undeveloped ideas about teamwork, other CPNs and Consultant 1 held a more *elective* approach. As was seen in the newcomer's approach to teamwork in the rehabilitation team, this approach was essentially monoprofessional. The implication was that their patient focus was individual, rather than becoming a team focus; *'my patients'* being a common phrase used to introduce their comments. The ramifications of this approach were that:

- communication was valued for being informative but brief
- role contribution would be clearly identified with the boundaries of that role being well defined
- there would be a lack of awareness of how the team contribution could be greater than the sum of the individual parts.

The conflict which occurred as a result of the mismatching of these approaches was evident in both the CMHTs and the PHCT. Where the *elective* approach met the *integrative* approach, there were *difficulties over communication*; those who held an *integrative* approach wanting more in terms of information and discussion of ideas. There was also the development of *professionally defensive behaviour* among those who held an *elective* approach, since they were required to extend their role beyond their professional identity. Where the *directive* approach met the *integrative* and/or *elective* approach, threats to *professional judgement* were prevalent.

Overall there was an inability to develop a *shared vision* of what the multiprofessional groups were providing and in which direction they were going. As a result, little discussion on 'team practice' was entered into; for their own reasons this was unlikely to provide the multiprofessional teamworking that all wanted to adhere to.

This section has *not* sought to show that one set of beliefs about 'multiprofessional teamworking' or another may necessarily lead to better patient care. Rather it has shown that differences in beliefs may inhibit the multiprofessional group from operating to the best of its potential. It is hoped it has also identified that simply holding what might be considered ideas which would lead to 'effective' multiprofessional teamworking do not necessarily encourage others to agree. In the case of the OT and SWs in the CMHT, it was clear that their ideas would have found favour to a large extent with Consultant 2. However, his difficulty in taking on challenges to his views in a way that may have allowed a broader approach to patient care to develop, overrode their beliefs. The problem for anyone coming into a team with different ideas would be the strength of the prevailing approach. This may be related to the number of people involved, and/or power balance.

The individual's philosophies of 'multiprofessional teamwork' described are not exhaustive, they simply emerged from the six case studies. However, the way in which people think about 'teamwork', and the power which may reside in those who hold perspectives which may not be as facilitative as others has implications for the ease with which alternative thinking may be introduced.

6.6 Learning implication

Students and those within existing teams need to understand the *importance of congruence across the team*, that different professional groups should share an understanding of how effective multiprofessional teamworking is achieved, in order to encourage a consistent approach to client management. Where this does not occur, team function is compromised and patient/client care can be adversely affected.

Key points

- There were difficulties in multiprofessional working where competing organisations and intra-organisational priorities influenced professional accessibility and time.
- The contrast in levels of communication, role understanding and development of multiprofessional practices between the 'core' and 'periphery' of the team adversely affected care.
- Both organisational issues and differences in individual philosophies of teamworking created problems for the integration of peripheral members to the core of the team.
- There was an important role for certain professionals in building bridges between the two groups in the teams.
- The communication style of senior members of the medical profession influenced the possibility for multiple perspectives on the patient to develop within the team.
- The development of current and future team strategies was influenced by the style of team leadership.
- These core and periphery practices suggested specific learning implications for students.
- Overall concluding comments included:
  - Collaborative teamworking may not be common. This may have implications for the transfer of collaborative practices.
  - Some members of high status professions inhibited collaborative working.
  - This implied the need for their early education which promotes collaborative working.
  - Organisational structures and processes were not generally supportive of collaborative working. Such contexts would prove difficult for the maintenance of education promoting collaborative practice.

7.1 Introduction

This chapter explores a third kind of multiprofessional working. The two groups discussed below seemed to stand between the degree of collaborative working in the rehabilitation unit and the rather dysfunctional, fragmented approach in the medical ward, the CMHTs and the PHCT. This type of working has been called *'core and periphery'*.

Chapter 6 highlighted the fact that the orientation of some members of professional groups, whose approach to interaction *could* have led to more collaborative working, remained primarily towards their own professional group. This occurred for organisational and cultural reasons. In two multiprofessional groups discussed in this chapter, a specific *multiprofessional core and periphery* type of working developed. Professionals in the 'core' were seen to be working in a more collaborative manner. Other professionals were distanced from this core for a variety of reasons, some organisational, some related to group process and some to individual beliefs about teamworking.

This poses a major question in relation to the spread of working practices. Chapter 6 illustrated that those whose individual perceptions of multiprofessional teamwork were similar and likely to promote a more collaborative type of working, were inhibited from developing their ideas because of prevailing patterns of practice, led by those in power. In the

multiprofessional groups in this chapter, there were to varying extents, professionals who *could* function in a more collaborative fashion with those in powerful roles. However, what prevented these core members from extending their practice to the periphery of professionals and incorporating them in this approach? Were they protecting their 'mini-team', were peripheral members uninterested in the core group's approach, or did organisational issues create barriers to incorporation? This chapter aims to provide some answers which may help to develop an understanding of the complex issues affecting multiprofessional working.

As in Chapter 6, the multiprofessional groups were different in terms of structures and processes. One was a child development assessment team, and one a diabetes team; both were specifically designated as teams and spanned the primary/secondary health care divide. Since they were designated as such, they are referred to as 'teams'. As before, evidence is drawn together and discussed using three levels of analysis: organisational, group, and individual. Although the *core* and *periphery* type of working is differentiated from the others in specific ways, similar patterns emerge. First however, the teams are briefly introduced, their composition and operation are described, and the main issues arising from the case studies highlighted.

7.2 What the multiprofessional groups were like

7.2.1 The diabetes team

This was the smallest group encountered in the research, and operated from a fairly new purpose-built centre in the grounds of a large general hospital. However, it functioned in a position which straddled the hospital facilities and community general practice.

Nationally there is a recognised diabetes team which includes the consultant, diabetes specialist nurses, chiropodists and dietitians; this composition was reflected in the team's day-to-day running, and in the literature in the facility. However, there were also perceptions of a core group which comprised the consultant, one of the two diabetes specialist nurses and a podiatrist (this designation differentiates this professional from the hospital chiropodists). With a community dietitian (now promoted into management), these members had pioneered the diabetes team and developed professional education courses on diabetes management. Other members had been employed later, and many were neither involved to the same extent with the team's professional education, nor had the same specific interest in diabetes. However all members of this team espoused a particular philosophy of diabetes care which stressed an educative and enabling approach designed to encourage maximum self-care.

The two diabetes specialist nurses worked permanently in the diabetes centre. Other members such as the consultant, chiropodists and dietitians visited regularly for clinic sessions. The team also ran clinics in the outpatients department. Weekly meetings were held for all team members in which it was intended that all professionals discussed patient care, new developments in diabetes care, and had presentations from outside speakers.

One of the main threats to multiprofessional teamwork was the *incorporation of newcomers* to a group where team allegiance was considered paramount. Those who had been in the team from its inception were highly valued by each other for their contribution. Enhanced by a stable situation, they had developed great trust in each other's competence and judgement, and learned to deal effectively with interpersonal issues such as managing a consultant who assumed power within the group. This group felt that they provided highly effective patient care through communicating information, ideas, and negotiated decisions. They also felt that by being fluid in role boundaries, they could maintain continuity of care, and at the same time, by being highly aware of each other's specific input were better able to make appropriate referral to each other. Further, they provided each other with a supportive working environment.

Newcomers were at a disadvantage for the following reasons. First, they did not all share the same overriding *interest in the diabetic condition*; second because of the *organisational context*, they were obliged to provide professional input to many other areas of the hospital,

compromising their input to the team; third, the *exclusivity of the original team* undermined newcomers' perceived professional value; finally the non-facilitative *communication style* of the consultant diabetologist was problematic. The newcomers did not perceive themselves as able to challenge the consultant. All these issues created resentment from one or both sides, which had been ameliorated to some extent by the communication skills of the diabetes specialist nurse who acted as an advocate for newer professionals with the consultant.

A final aspect of this case study was the effect of *organisational fragmentation* on some members of the wider multiprofessional group (staff in the outpatient facility). Although they had been interested in diabetes, removal of the diabetes centre from the main hospital had effectively diminished communication between these members and those working in the centre, making them feel more marginalised than previously.

7.2.2 The child development assessment team

This second team also operated from a purpose-built centre within a hospital's grounds and provided assessment and therapy mainly for very young children with special needs. It comprised SLTs, HVs, OTs, a playroom teacher, a SW, PTs, consultant paediatricians, clinical psychologists, nurses, nursery nurses and a centre co-ordinator. Except for the PTs, all professionals had an office and practised in the centre. This large number of professionals came from different trusts and agencies, hence the team structure and interaction was complex and confusing. Like the CMHTs, many professionals had *separate and different case loads*, operated with *different foci*, and had *separate line management*. In this team, however, a multiprofessional subset had developed, which worked collaboratively.

As with the diabetes team there was an acknowledged core comprising a SLT, a HV, a consultant and the playroom teacher. These professionals had developed some *highly structured assessment, therapy and case discussion sessions*, in addition to regular weekly whole-team meetings. These case discussions were open to all professionals and provided regular forums for debate on different aspects of the team's work.

The core group also shared *similar ideas about a collaborative type of teamworking*, and had evolved joint working practices and to some extent a shared note system. Two of these professionals could identify the influence of *prior experience* which led to these beliefs. The relationship between others in the team and the core ranged from them being to some extent included, to being very distanced and antagonistic. In general it did not seem possible to 'bring on board' most other team members to this type of working. This related to *historical incidents, perceptions of a specific orientation to the work of the assessment centre, and organisational pressures.*

The whole team had spent time in six-monthly 'away days' grappling with what kind of service it was, what it provided and how it was provided. Despite many attempts to define themselves and their practice, a major issue was the lack of a *shared vision of practice* and a *sense of direction*. This related to difficulties in giving time to *regular reflection and discussion of the issues*, but also a lack of a *common philosophy of teamwork*. Given the various foci, separate line management, and the persistence of different professional cultures, this was not surprising. However, the team also felt that it lacked a *strong but facilitative leader*.

Section 7.3 examines some organisational aspects which hampered the combining of the 'core' groups with the more peripheral team members. These include: *geographical proximity, competing organisational priorities, competing organisational policies, lack of shared focus.*

7.3 How the organisation affected multiprofessional working

7.3.1 Working close together

It was noted in Chapter 4 that working in proximity with other professionals can create facilitative conditions for the development of collaborative working. It can foster ongoing *ad hoc* communication and allow social interaction, which helps to underpin effective professional communication and role understanding. It need not, however, fundamentally affect the amount of time professionals are involved in clinical discussion, or joint practice. Working in the same location is, therefore, only a starting point for effective multiprofessional working. The teams discussed below identified lack of geographical proximity as a factor in divisions between some members. However, other organisational factors seemed to have far more impact.

The diabetes centre housed only the specialist nurses as residents; of the other team members, only the consultant was a daily visitor and had his own office. The dietitians and chiropodists had a work area, since they only attended once or twice a week for specific sessions. The podiatrist, who was a fundamental part of the core group, visited periodically for a special clinic session; otherwise he was only seen in the outpatients department once a week. His involvement with the team in terms of face-to-face contact was similar to the two professionals discussed below, who had previously been highly involved in the team's work. However, they were seen as peripheral members.

In the early life of the diabetes team, it had been situated in the hospital and operated largely from the outpatients department, where one nurse and a clinical assistant, both extremely interested in diabetes, ran clinic sessions with the consultant, one specialist nurse, the podiatrist and a dietitian. The nurse had taken specific training in diabetes management, and the clinical assistant, who was a local GP, had made it his main professional interest.

This situation changed when the new centre opened, with the main emphasis of the team's work now being in the centre. There they engaged in education and monitoring of patients, leaving only 18-monthly full reviews to be managed in the outpatient department. The clinical assistant and the nurse now felt alienated from the process of diabetes care and other team members. Instead of seeing patients from initial assessment through educational input and stabilisation to ongoing management, they now only saw one part of the process.

Both the clinical assistant and the nurse had valued their sense of continuity with patients, and regretted the loss. In terms of their association with the team, they felt *'out of touch'*, complaining that information relating to changes in policy or practice, or even appointments for patients, did not reach them. Because of the distance and times involved, both found it difficult to attend weekly meetings, compounding the divide between them and professionals in the centre.

For members of the child assessment team the provision of shared office and working space did not seem to bring many peripheral team members into the core group. For example, the clinical psychologists were widely seen as distant members, despite being in the building several days a week sharing an office with the SW, and one of their number regularly attending weekly team meetings.

The SW had been seen as more of a core member until changes in his practice forced him to reduce his input by two thirds, and to become unpredictable in attendance at the centre. Only the PTs worked and had their office in a separate location from other team members. Despite their attendance at weekly team meetings, and input at one play session in the centre, the geographical separation was seen by many to be the reason this group of professionals was not part of the core group. Comparison with the position of the clinical psychologists however, negates this perception to some extent.

In the diabetes team, the difference for the two professionals from the outpatient department, seemed to stem from their lack of involvement in the whole process of patient care, rather than their geographical dislocation. Did this apply to the PTs? Not really; in addition to attending team meetings and playroom sessions, they had the same opportunity as others to take part in many clinical forums in the centre, and be involved in the assessment process. However, like the clinical psychologists, they did not do this consistently, for reasons discussed later.

Geographical proximity for these teams and their members may make no difference to the way in which team members are perceived. For example, the podiatrist was still a core member even though his input to the team was small and professionals saw little of him. The clinical psychologists in the child assessment team had an office in the centre and were regular visitors, however, they were universally seen as the most distant team members. The SW had been a core member but now operated at the periphery, though his office remained in the centre.

This suggests that geographical proximity may be important in helping to foster initial team cohesiveness through the facilitation of social communication, but is not necessary in order to maintain that relationship. Furthermore, it can be used as a ready excuse for poor teamworking. As with the CMHTs in Chapter 6, being in the same geographical space seems to have little impact on increasing effective multiprofessional working, whereas clinical discussion and joint practising does.

7.3.2 Stability

The diabetes and the child assessment teams were both affected by the short-term nature of some of members' employment, but for different reasons. In the diabetes team, there had been problems recruiting dietitians over the previous three years. As a result there had been a series of locums brought in, none of whom stayed for longer than six months. This was acknowledged to have undermined the profile of the dietitians for other members of the diabetes team.

This team had begun its life with ongoing input from one dietitian over several years. She was perceived by the other core members as an important and valued member of the team, and her own interview supported this perception. After her promotion, locum dietitians had taken over her post, and none were regarded by core members as part of the team; even their names were forgotten.

This situation helped to create divisions between the dietetics department and the core group, and was reinforced by the fact that the diabetes team felt it should have been able to appoint its own dietitian. Core group members recognised the benefits of having a professional in post who had developed an understanding of the particular patient group. These were chronically ill patients who had been known to the team for years and for whom an in-depth knowledge of their condition was helpful in making decisions about management of care. By the time the two new permanent dietitians joined the hospital and the diabetes team (two months prior to the study), it was clear to them that they would have a difficult task in terms of establishing their worth as a professional group.

In the child assessment team, some PTs also had short-term involvement. Junior PTs were on six- to nine-month rotations with the hospital and were expected to spend some of this dealing with children treated in the centre. In tandem with this, the more permanent PTs were a large group who shared the responsibility of liaison with the centre among themselves. This involved having one of two PTs who attended the playroom, one of two PTs who attended the team meetings, and yet two more who attended the assessment process. This allocation to particular area also changed during the study.

The combination of short rotations and a diversity of regular PTs coming to the centre, resulted in a situation where other team members did not have a chance to develop long-term close working relationships with any PTs. Further, the PTs who came to the team meetings often did not have all the relevant information on a particular patient, since they may not have been working with that patient themselves. Finally, as in the diabetes team, the patient group was likely to be managed by the centre for a number of years, so that building up physiotherapy knowledge of a particular group of children would have been important in determining professional programmes of care.

In both these situations it can be seen that there would be difficulties in communication resulting from the instability of professional input. In both teams, unstable professional input helped to compromise the building of 'team knowledge' about a *long-term group of patients*. While in the acute sector of the NHS, stability would seem to be a contradiction in practice terms, for the management of chronically or long-term ill patients, it is an important aspect of multiprofessional team function. It allows professionals to reflect on prior management and the reasons for previous decisions, and allows them to compare patterns of illness and treatment in various circumstances in order to rethink the results of specific professional input.

7.3.3 Competing organisational priorities

The diabetes team exemplified the situation where a specialist group was struggling to work in an organisational environment which demanded the attention of some members for wider tasks within the hospital. The consultant, specialist nurses and podiatrist had designated roles as diabetes team members (although the podiatrist also had specific teaching duties); for the chiropodists and dietitians, their role in the team was simply one of many in their daily work. As other calls on their time included attention to more acute work (unlike the podiatrist whose other work was predictable), their priorities of working conflicted with their work in the diabetes centre on occasion.

This lack of specialist designation of some members of the team created difficulties for the core members, for whom the work of the team was paramount. When assessment sessions were running for new groups of patients, they expected dietitians, for example, to stay until the end in order to engage in a short debriefing. However, the dietitians at times withdrew in order to complete their paperwork. When they were holding monitoring clinics in the outpatients department, the core group expected all patients being seen by the dietitians to be diabetic. Where members of the core group wanted a patient to be seen urgently, they expected the dietitians to make space in their day rather than the patients having to wait. Communication in these aspects of multiprofessional working was adversely affected. Opportunities for clinical discussion and informal conversation were missed, and delays in the dietitians' responses resulted in patients waiting for information as well as treatment.

The perceived lack of consistent attention to the work of the team angered the consultant and the specialist nurse in particular, and their anger was made known to the dietitians. Both these core group professionals had a strong commitment to the concept of a specialist diabetes team, and felt that all its members *should* be specifically designated; their allegiance should be primarily to the diabetes team. Only through such a focus did they feel that team members would provide the consistency and continuity required for their patients. The consultant, in particular, commented that specialism went hand in hand with greater motivation, since presumably the professional who joined such a team would be making a positive career choice.

It seemed that the lack of designation to the diabetes team, and the resultant competing priorities, fuelled a lack of role understanding among core members. Much of the dietitians' work elsewhere was invisible to them, and they interpreted lack of dietetic response as obstructive rather than an inevitability, given the acute nature of this other work. For some teams, lack of role understanding may be governed by the organisational situation, with professionals' desires

to know more about others' roles able to make little impact. In this team however, the core group seemed *unwilling* to accept the limitations for the dietitians; they did not want to know about the wider role which created the problems.

How did peripheral team members respond to the adverse reactions of core members? The dietetics manager in interview felt unjustly treated. There had been a reduction in dietetics manpower, leaving only three people to cover the whole hospital. She believed there was no room for manoeuvre, and was angry at the apparent lack of understanding shown by members of the core team. However, she and the other dietitians refused to be *'bullied'* into meeting criteria set by the diabetes team over and above their own professional criteria. Prior to the study, the dietitians had withdrawn from the team meetings as a protest. Instead of allying themselves to the diabetes team, monoprofessional allegiance became more evident.

In the child development team, a similar competition for priorities was seen, but with a different emphasis. Being a member of the child assessment team formed only part of most people's role, therefore competing priorities were generally likely. Many had commitments in the community, and dealt with separate populations of children. However, most of their external work was appointed and therefore predictable (even though sometimes heavy in volume). In order to attempt to focus the referral pathway, some professional groups had identified a single person to act as the main representative for the assessment and therapy aspect of the work. The SLT core group member, one OT, and one clinical psychologist had been identified, for example.

The situation of the PTs was different. Not only was their wider work likely to be of an acute nature, being unappointed and unpredictable, but a large number of PTs attended the centre. These factors in combination made it difficult for other team members to understand why PTs had not attended sessions or meetings, or who should be attending in the first place.

Unlike the diabetes team, competing priorities and the lack of a designated professional did not create the same level of consternation; it simply reinforced the peripheral nature of the PTs' position in the team. Why was that? In the diabetes team, those who were perceived not to match the high level of commitment to diabetes required by core members seemed to be viewed as an out-group; *'them'*. It would seem probable that a negative perception of those with competing priorities outside the team's work would relate to the strength of cohesion among team members. The lack of adverse reaction from other members of the *whole child assessment team* highlighted this point. The lack of response from the members of the *core* group was not strong because their focus was different from that of the PTs. Both these factors are discussed in Section 7.3.4.

7.3.4 Lack of shared focus

Part of the reason for the rehabilitation team working together so well was because it had a discrete purpose. All its members had a single focus to which they operated; the development and execution of neuro-rehabilitation programmes for one patient group. The specificity provided by that focus allowed the development of specific ways of addressing patient care and therapy, since all patients were dealt with by all professional groups initially, and to a large extent during the course of the patients' programmes. In short, *all* professionals needed to be in involved in in-depth communication and to understand what each other was doing, how, and why.

This was not the case for the multiprofessional groups who displayed fragmented working; some professionals needed to be in contact, others did not because they addressed different patient/client groups. If referral was necessary in the latter case, referral criteria were important to understand, but would professionals necessarily need to understand how the role was carried out and the rationale behind it? This raises a question about the devising of the 'multiprofessional team' where there is not a shared focus; why is it functioning as a 'team' at all under those circumstances?

For the diabetes team, despite some members having other calls on their time, when in their diabetes team role, clearly all professional *did* have a shared focus. The reasons why some members developed a core group related partly to the issue of competing priorities among peripheral members, and partly to group process issues. For the child development assessment team, however, sharing a focus was not the case for the team as a whole.

In general terms in the wider child assessment team, several different population groups were being seen, none of which overlapped for the *whole team*, but some of which overlapped for groups within it. For example, the SLT in the core group had a focus involving the early years provision of speech therapy to children with more complex special needs. She did not see children once they had entered educational provision (often at three years old). This heavily overlapped the focus of the playroom teacher and one of the nursery nurses. However, these professionals also worked with young children with physical and sensory problems, such as cerebral palsy and blindness (some of this work overlapped with the PTs and OTs). The consultant in the core group had a wider but partially shared focus with the SLT and a matched focus with the playroom teacher. The HV's work was shaped by those seen in the centre, therefore matching that of all these professionals.

By contrast, the PTs saw all children from the hospital population up to the age of 16 who required physiotherapy, children with special needs in schools, as well as younger children requiring the service. The clinical psychologists were part of the child and adolescent mental health service (CAMHS), which was responsible for all children referred by the hospital, community and Centre consultants with behavioural problems, up to the age of 16. This meant that only a small proportion of the CAMHS group's time could be spent dealing with children with special needs who also had behavioural problems. However, some of these children would have overlapped with the SLT and playroom teacher's work (the reasons why this did not happen are discussed later).

As seen in Chapter 6, lack of shared focus restricts a team in developing a shared approach to care, and consequently an overall team direction. The child development assessment team was no exception, indeed a widespread perception was that it was merely a group of professionals who share a location, some of whom needed to interact. As seen in several of the multiprofessional groups, in this situation the only profession that all members would *need* to interact with, would be the medical profession; for others it would be as and when relevant. Therefore the need for in-depth discussion and the sharing of specific professional knowledge, *across the whole team*, would, arguably, not be required in the same fashion. Further, the development of in-depth role understanding *across the whole team* would not be as relevant, since ongoing professional interaction would not necessarily occur.

Given that many 'multiprofessional teams' are defined by broad function, rather than specifically what they do, developing a sense of belonging to a venture known as 'multiprofessional teamwork' under these circumstances may be impossible. Perhaps multiprofessional groups working under such adverse conditions need to identify where natural partnerships occur and foster better working between the individuals concerned.

What of the core group in this team? This group did operate in a much more collaborative fashion, partly because their work overlapped to a greater extent. Other issues facilitated this type of practice, but shared focus was a significant factor. Over a period of a few years, the emphasis of the *therapeutic* work in the centre had shifted from those with physical problems such as cerebral palsy and blindness to those with language and social interaction disorders. There may have been demographic reasons for this, but it may also have been partly related to the strength of the core group and their interests. Diagnostic and monitoring clinics, developmental play sessions, and assessment sessions took up a large percentage of session time in the centre. However, language and social development groups, in addition to individual speech therapy sessions dominated the programme for the week. As far as the assessment and

language disorder aspects of the work were concerned, there was a 'team' which shared a focus, had developed a philosophy of care, and had a sense of direction *for itself*.

7.3.5 Separate management structures

The potential difficulties have been identified for multiprofessional groups with separate management and members who want to develop their 'team' practice. In the diabetes team the non-designation of the dietitians had long been a source of irritation to the consultant. Despite the extent of medical power, and the subsequent case made by the specialist nurse, it was not possible to alter the way in which the dietitians organised their work, nor to effect the resources for an additional dietitian. While this was understandable given the shortage of resources in the trust, it was perceived that the lack of negotiation across professional management did little to help find alternative answers to the problem.

In the child assessment team several professionals wanted change in order to facilitate better management of such a disparate group of people. These ideas were discussed at their away days. However this system seemed to frustrate team members more than help, because nothing meaningful was seen to develop from the discussions. Several professionals perceived this was partly related to the lack of a multiprofessional management structure. There was no route by which the heads of each service could come together regularly to promote, discuss and develop ideas from their own professional group which could have facilitated a cohesive team. This was recognised by some professionals as helping to perpetuate the peripheral position of people such as the clinical psychologists and PTs. The supervisor of the PTs corroborated this perception; she wanted to take part in the decision making process of team development, but felt unable.

There *was* however, a management structure associated with the centre but this did not include representatives of all professional groups in the team. It simply included the clinical director, a rather distant figure rarely seen in the centre, the consultant and HV from the core group, and the centre co-ordinator. These people met monthly to discuss business matters rather than clinical issues and changes to practice; it was management of the centre rather than the team.

While reasons were put forward for why this management structure was not as widely multiprofessional as it could have been (size of the group and difficulty getting people together), the problem remained that those who had ideas to put forward were cut short by the lack of discussion at a higher level. Over time, this lack of team progress had demotivated several professionals. Given that many members had an awareness of the need for time together to discuss practice, it was disappointing that these discussions were largely fruitless. If multiprofessional teamworking is to be a fundamental fact of organisational life, it would seem that further thought should be given to providing multiprofessional management structures to help facilitate their practice.

How can students be helped to understand the impact of these organisational aspects on multiprofessional working? The following learning implications which arose from the way in which the organisation impinged on these teams' working will be familiar, since they were also relevant for multiprofessional groups whose working was fragmented.

7.3.6 Learning implications

Students should understand:

- the effects of *competing prioritisation of work* by team members and how this might challenge team cohesiveness
- the *difficulties created by having mixed designated and non-designated team members*, and that this can lead to team divisions related to undervaluing of the role, and resentment over competing allegiances between the team and other teams

- the *context within which they are operating* in teams: the organisation; its policies, structures and processes, and how these might impact on the team
- the development of strategies to deal with the *fluidity of the organisation* is necessary, i.e. the management of change. This may mean being more open to more *fluid role boundaries*
- that lack of *joint management structures*, which access power bases, can hamper aspects of team practice change.

7.4 What it meant to be a team member

7.4.1 Beliefs and values

Examining the beliefs and values held by professionals in the diabetes team it is apparent that it *could* have developed highly collaborative teamwork. To a large extent, all professionals, except one, shared similar views about patient care, with the best way to provide that being through close multiprofessional interaction (this exception, the second specialist nurse, is discussed later). There was a set of *group beliefs* in that they all understood that effective patient care needed a combination of information and knowledge, in-depth discussion to achieve 'team knowledge,' and a clear understanding of how and why particular roles functioned to bring about the best service delivery. However, the core group had developed in a specific way which differentiated it from other members, and created a barrier to the coalition of these beliefs.

With the additional input of a dietitian (long since moved on), this group had been involved in the *evolution* of the diabetes team; they were founder members. Although all had extensive understanding of diabetes they had attended conferences and given papers together in order to improve and maintain their knowledge. Further they had developed education in order to help other professionals become acquainted with the problems of managing diabetes in the hospital and the community setting. Indeed they had helped to establish satellite diabetes clinics in general practices locally.

This had involved a great deal of initial and ongoing discussion about the practicalities and the philosophy of the diabetes team. This had been developed in line with international thinking and was essentially an educative and inclusive model for the patient, who should learn to manage their illness, with support from the team. This was promoted by all core members in their education programme to other professionals as well as in their clinic sessions with patients.

This shared philosophy of patient care was incorporated in an approach to 'multiprofessional teamwork' in which they recognised the need for attention to the three aspects identified in the rehabilitation team, clinical, team practice, and social. Through the process of team development they had gained in-depth understanding of each other's strengths, weaknesses, skills and knowledge. The latter they were able to share, and subsequently to trust each other's judgement in circumstances when they were not available.

For example, the podiatrist was able to admit patients without referral to the consultant, and the nurse specialist had extended her skills in insulin vs oral prescription. Both these actions would be discussed with the consultant as a team process, but nonetheless they did step into the traditional preserve of the medical profession. In effect the role boundaries of the core group were similar to those of the rehabilitation team; they were perceived to be flexible and fluid, responding to the situation. In addition to their willingness to be role flexible, all current core group members were confident in the specificity of their own role contribution. For example the specialist nurse had acquired skills in managing adolescent diabetes, a particularly sensitive period both physically and psychologically. She ran an informal clinic geared to adolescent concerns, in which the consultant was observed to defer to her judgement.

The problem for other professionals in the team was that the level of collaboration shown by these three was not extended to others. Other professionals shared many of the core

group's beliefs about multiprofessional working, but were not given the opportunity to express these. An example of the limiting of dietetic input has already been cited. The way in which other professionals were communicated with in the team meetings was another.

These meetings were supposed to be weekly case reviews. However, in the course of the study this agenda was not pursued; instead the meetings were used by the consultant to 'talk at' other members. Observation confirmed that if the specialist nurse was absent, the consultant conducted a monologue, virtually lecturing others about new research findings, for example. Often the only other voice was that of the senior registrar with whom the consultant 'sparred'. When the specialist nurse was present she did steer the conversation to other issues, but it was still hard for other members to make an impact. In these situations the specialist nurse was regularly left to input to the conversation in order to attempt to make an entry point for others. Communicating under these circumstances became safer and easier to do by letter, which was a common occurrence.

The division between the two groups of team members was sharply focused by this difference in communication. The extent to which it could limit knowledge and information would be damaging, given that this was the only formal case discussion time. Members of the core group pursued discussion during clinic sessions, but lack of core membership inhibited others from taking *ad hoc* opportunities in the same way. The team relied for its channels of communication on the specialist nurses.

The child assessment team was different in the sense that beliefs outside the core group varied; several other team members shared the beliefs of the core group, while others operated from an alternative framework. A large percentage of team members were clearly aware of the need for a collaborative multiprofessional approach to patient care. They also recognised the benefits to patients identified by members of the rehabilitation and diabetes teams, and with one or two exceptions, were willing attenders at away days which addressed issues around team practice to improve patient care. Like the diabetes team, there *were* group developmental and process reasons why those with similar beliefs did not become incorporated with the core group, but here the emphasis was on organisational issues such as separate line management structures, stability of staff, and competing priorities.

How had this core group developed such collaborative multiprofessional practice? One factor here was the *degree* to which they were changing practice, another was their *shared patient focus*. As disparate a group as worked in the centre would have to make major changes in order to develop more collaborative working. The core group had, through their ability to focus on their shared client group, been able to make small, in-house, changes to the organisation of their time. They had developed a system of assessment sessions and feedback forums, and a number of other forums for debate specific to case review. These incorporated the use of 'agreed' notes in that discussion at the end of sessions facilitated the writing of notes which did not conflict, and which could be put together as a joint report for parents.

Like many members of the diabetes and rehabilitation teams they recognised the need for professionals to feel equally valued, and able to demonstrate their skills and knowledge in order for each to learn from the other. Two members of this core group had experienced working in a more collaborative fashion in previous posts; the SLT and the consultant. Unlike many of the medical profession identified in the study, the consultant readily deferred to the knowledge and experience of others, and cultivated an informal climate in the centre. She was perceived as a supportive colleague and was observed to do this regularly.

Sharing information, knowledge and skills was a fundamental aspect of the care group; a major point of differentiation from the clinical psychologists in the team. Here, there were tensions around sharing information and knowledge. Confidentiality was put forward as a reason why they did not share with others. This left other professionals with whom they had patients in common, unaware of aspects of *their* patient's progress, unprepared for how to deal with difficult behaviour, and lacking in understanding of what clinical psychology actually

contributed to the team. Furthermore, the issue of confidentiality was interpreted by others as undervaluing their professional integrity.

All professionals within health care and social services expect to enter into a confidential relationship with patients/clients. Where services need to be co-ordinated across professions there is an understanding that information about physical, social and psychological issues will be passed between professionals within an agency. Where other agencies are concerned, as for example when social services needs to exchange information with health care professionals, their client's permission would be sought in order to disclose aspects of their family life for example. However, members of the psychology service maintained that the whole basis for in-depth disclosure would be predicated on the confidential nature of the interaction.

It could be argued that the main purpose of any such service should be to meet the needs of the client, and that failing to protect disclosures made during therapy sessions would *not* meet their needs, unless it was related to the safety of a child, for example. However, *all* professionals apart from the SW complained that they had little or no feedback, even though they had been directly involved in the referral. The concept of there being a degree of team knowledge allowable within the confines of confidentiality did not seem to be tolerated by some of the clinical psychology group.

This level of knowledge guarding obviously impacted on how other professionals were able to co-ordinate their service, but also compromised their own input to a particular child or family. Furthermore, while notes about sensitive disclosures would understandably need to be managed in a confidential manner, information about a child's progress within a behaviour modification programme for example, would not seem to fall within that framework. So for example while a *counsellor's* feedback would be necessarily summarised, one would imagine that details of the *clinical psychologist's* input with a child would be more comprehensive.

Several PTs seemed to share many of the core group's beliefs on multiprofessional working, yet were not incorporated within it. Why? Although the organisational issues described above would have affected their incorporation, there had been a legacy of difficult relationships fostered by perceptions of *'domineering'* physiotherapy behaviour.

The physiotherapy supervisor described an incident prior to the employment of the playroom teacher, when two nursery nurses ran some of the play sessions. Neither had specific training in the management of children with physical problems, and the supervisor perceived that the sessions *'were not functioning well'*. The PTs took it upon themselves to help the nurses learn about handling children who had, for example, cerebral palsy. This had not been received well and one nurse had resigned her post. As a result, the PTs had been treated as 'black sheep' for some time.

The style with which professionals share knowledge or inform others has been identified in other case studies as inhibiting involvement in the communication process and compromising professional development. However one incident would not have been sufficient to create a long-lasting effect, and indeed, others in the centre still called some of the PTs *'bossy'* and *'domineering'*, citing further evidence of a continued abrupt manner when dealing with other professionals, and with parents and children.

However, this type of negative attitude towards the PTs was not expressed by the OT. These two professional groups had a long history of working together in schools and it may be that either the OT did not interpret the behaviour in the same way, or that she had learned to manage it more effectively. Because the PTs did not work regularly with the core group, it is possible that the old behaviours became established as a barrier to developing ways of coping with this style. Any group of professionals would be likely to contain members with problematic ways of communicating. Where high status and power are involved, it can be difficult for others to surmount the problem. However, in this case, where power differentials were not readily identified, poorly perceived communication could have been more readily dealt with.

Previous chapters identified the benefits or otherwise of *a facilitative style of leadership*, a *directive leadership defined by role power*, and *power being used without leadership*. Within these two teams, the second variant was identified, and a fourth emerged: *lack of leadership*.

The diabetes team provided an interesting example of a dual approach. The consultant seemed to operate as a one among equals within the core group. The long history of this group of professionals had included both social and professional interaction. From interview evidence with all three core members, it was clear that the consultant operated to a large extent as a friend and professional equal with the diabetes specialist nurse. The specialist nurse perceived discussions with the consultant to be as likely to include specific clinical discussion as professional support. Further, she had acquired a great deal of experience of day-to-day management of diabetes which she felt was listened to and acknowledged by the consultant; he came to her for advice on particular areas of patient care.

While the level of friendship was not so evident between the podiatrist and the consultant, on a professional level the podiatrist's input to the decision-making process was considered as important by the consultant. Here too he acknowledged the specific knowledge of, and sought the advice of the podiatrist; saying of the podiatrist *'if he says it must happen then it does'*. This was confirmed by the podiatrist. Where the three professionals were seen in discussion, it bore many hallmarks of interaction seen in the rehabilitation team.

The consultant's interaction with those on the periphery of the diabetes team was more directive, in a way which did not encourage their input; indeed stifled it. The consultant seemed to perceive the dietitians and chiropodists as barely team members at all. He apparently did not understand or tolerate the ramifications of their non-designation to the team. Interviews with these peripheral members showed that they saw him in a traditional stereotypical fashion, and observation of his interaction with them corroborated their views. In one joint case discussion where the dietitian was present, the consultant addressed all comments about diet to the specialist nurse, making it difficult for the dietitian to express her views. Where she did speak, this was overlooked by the consultant.

In addition to his stance on those who were not designated team members, this professional also had a difficult manner which core members had learned to manage. In keeping with many senior medical staff discussed in Chapter 6 and later in this section, the consultant could be abrupt and abrasive. The nurse specialist and podiatrist were observed to 'cut through' the consultant's communication by changing the subject, disagreeing with him, and particularly in the case of the specialist nurse, to advocate for other team members. Those on the periphery did not interpret the consultant's behaviour as leadership, simply as use of power to push through his decisions. For those who were not assertive this could result in a complete overriding of their input to the decision-making process.

This professional's dual behaviour was disruptive but understandable. On the one hand, if he was working with other professionals whom he felt were committed to diabetes care *and* to the diabetes team, and whom he had learned to trust, he seemed prepared to listen and acknowledge their professional input. It was necessary for others in the core group to be as assertive, but given that, he treated them as valued equals. However, where he felt that team members had other priorities which may override team priorities, and where those professionals were regularly changing so that experience of the patients could be compromised, it seemed that he felt that their input was not as valuable as that of the core group. In some ways his response mirrors that of the rehabilitation team who would be prepared to 'lose' anyone who did not fit into the team culture. A professional was required to be like them or leave; there was *'no choice in the matter'*. The difference in the diabetes team was that the consultant did not give other team members the benefit of the doubt and attempt to incorporate them.

The situation in the child assessment team was very different; they lacked leadership in the sense that one or several people could spearhead changes to the team's practice, and help to give it direction. There was a clinical director of the centre but she was not perceived by anyone as a member of the team. Her involvement in management meetings was inconsistent and it was hard for professionals to know what to expect from her. Furthermore she was not involved in any team meetings, nor did she regularly feed back information to the team. One professional, who took it upon herself to see the director to clarify long-standing rumours about organisational changes, said that the director always understood that information reached team members *'by osmosis'*. It was clear that she had little understanding of the disruptive influence of rumour in an already disaffected group.

The clinical director did attend some away days, but did not appear to help the professionals to take forward any suggestions regarding change of practice. For example, two away days had explored the idea of recognising the different foci and devising teams around those; to have 'teams within a team'. In effect this had already been achieved by the core group, but there could have been several other focused groups. At the end of the away days, no one had taken it upon themselves to investigate the best way to do this, nor had further meetings been agreed to discuss future plans. Team members became disheartened at the lack of progress.

Several team members commented on the need for one person who could gather ideas and discuss them with each professional group's management, in order to promote change. This reflects comments made in the CMHTs and indicates a particular problem for multiprofessional group working. In the rehabilitation team, the director or professional managers responded to suggestions by taking them to the joint management meeting, discussing them and feeding back possible solutions or agreements to change, to other members. Organisations need to think about the kind of negotiation that is possible across management structures, but prior to that there needs to be an identified person who can move ideas forward. Unlike the PHCT and one of the CMHTs, where there was use of power without leadership, here the democratic or disengaged nature of the consultant's involvement and the distanced working of the clinical director effectively meant there was no leadership. In this situation the same person may not always need to take the role of leader, but responsibility for spearheading actions needs to be identified at the time of the decision to change. Without that responsibility being allocated, a common outcome would be for it to be abrogated.

7.4.3 Knowing how the professional roles contribute to the team

If one part of the team is working more collaboratively than the remainder, how does that affect professionals' perceptions of role contribution, the need to understand other's input and the value that is ascribed to their roles?

In the diabetes team, the core group had no doubt about each other's contribution, exactly how their colleagues' reasoning had led them to their conclusions, and the value their expertise brought to the process of patient care. Others in the team did not share those feelings, particularly the hospital chiropodists. One was part-time and rarely seen in the centre, but the other regularly attended clinics and education sessions with new patients.

In her two years in post she had become resentful of her treatment in the diabetes team. She felt that the consultant often sidelined her opinions and gave work which should have gone to her, to the podiatrist. She was confident in her expertise as a chiropodist, although she had no specific grounding in diabetes. She believed that her expertise was being *'wasted'* in the team because it was so rarely sought by the consultant. This was corroborated by observation, but raises an interesting point. Why was it apparently only possible for the chiropodist's role to be validated by the consultant? She had a good relationship with the specialist nurses, often discussing particular cases and giving her opinions about patient management. Would not this have been a way for her to have developed credibility as a team member? The main problem for this chiropodist however, was her lack of standing as a *diabetes* chiropodist, and in this she

could not, and did not, want to compete with the podiatrist. As such, she was likely to remain less of a team member, because her role contribution was deemed by the core group to be, in that sense, less valuable.

The dietitians suffered the same fate as the chiropodist in being overlooked by the consultant. They did not have a specialist dietitian to compete with, but their response to this behaviour was the same. They were newly trained but clear in how they wanted to act as team members. They were confident that they should be part of the whole process of care, and did not feel that their role was being used in the fullest sense. One dietitian in particular felt she was *'the last resort'*, sought only when a patient's dietary management was causing major problems. This echoes the OT's feeling about the limitations of her role in the CMHTs, and expresses an holistic understanding of multiprofessional teamwork where all team members are involved in a comprehensive approach to patient care. However, it must be remembered that, like the hospital chiropodists, their role in the team was limited by other priorities, therefore their aspirations would have been hard to achieve.

The existence of a core and periphery in a team poses problems of communication and understanding. One role, taken by the specialist nurses in the diabetes team, helped to overcome the divisions to a certain extent by creating communication pathways. The specialist nurse in the core group was confident and assertive, and had little difficulty in coping with the rather abrasive communication of the consultant. She was able, to some extent, to act as part of a bridge between the consultant and peripheral professionals, and did this in tandem with the second specialist nurse.

Because of the trust she had built with the consultant, she was able to discuss aspects of care, or questions raised by the other professionals with him. She then talked over the results of these discussions with the second specialist nurse, who had worked in the team for some years but, unlike the core group nurse, had developed a close working relationship with the hospital-based professionals. In this way she was better placed to pass on information and requests to them. Furthermore, she was considered by the chiropodists and the dietitians to be a good listener, and to give them time to express their difficulties in meeting the consultant's requests.

This professional was a gentle, shy person who had also found it hard to deal with the consultant, but for the hospital-based professionals, she was a natural ally. After discussion with other peripheral team members, she was able feed back to the core group specialist nurse, and so to the consultant. In this rather tortuous way, communication was achieved, and, one hoped, it would be possible to develop an understanding of the problems as perceived by the hospital staff.

A similar role was seen to be performed by the HV in the child assessment team, although not in the sense that she helped to smooth over communication rifts, rather, she offered a collating and information dissemination service. These were specific aspects of her role, but had been envisaged as providing a link between community services and the centre. For example, she would be expected to contact community HVs to ensure they had information about the centre's activities and were passing on information about children in their caseloads who may need attention. However, she also developed a stronger link between some hospital-based staff, such as the dietitian, the ward nurses, and members of the team by regularly visiting these professionals, discussing new cases, sifting out relevant information and passing on what she had gathered.

In her approach to her work within the team this professional was also seen to facilitate more effective communication. With the help of the core group consultant she had developed a system of case review in which *all professionals* were expected to provide her with a list of all relevant children. From this, she drew up a list of children to be discussed at a weekly meeting chaired by herself. All the core group and the OT assigned to young children attended this meeting. The HV, supported by the consultant, was trying to encourage the PTs to attend

regularly. The clinical psychologists had made it clear that they were opting out of this and did not supply information to the HV.

The OT, who perceived herself, and was perceived by core group members, to be *'moving towards the core group'*, felt that the case review system had improved her interaction with them. It had enabled her to engage in regular discussion relating to specific children, and to demonstrate the usefulness of her input. On one occasion, the OT's observations about a child created a better understanding of his condition, and changed the programme of care which the SLT had devised. It was hoped that the PTs' attendance at the meetings would facilitate a similar experience for them, and thus bring them further into the core group.

In some ways, the SLT had tried to develop a bridging role between the core and the periphery but without long-term results. When she first arrived she had arranged discussions with the playroom teacher about the possibility of joint practice; a raft of joint sessions had been developed through which both professionals had gained insight into each other's skills and knowledge. Now, with the HV, and in close communication with the consultant, they felt themselves to be providing more continuity and consistency of care.

Subsequent to her success with the playroom teacher, the SLT proposed similar discussions with the PTs. She had hoped that by working with them, she would be able to maximise her work with speech development as a result of the children having been physically relaxed and seated appropriately. Like the SLTs and PTs in the rehabilitation team she recognised the benefits of gaining physical control and comfort on the ability to acquire cognitive skills. She also hoped that in the course of this process the PTs could learn some strategies for helping children to communicate, and she could learn some strategies for seating and positioning.

Unfortunately the sessions did not develop in the way she had hoped. She felt that either the PTs did not see the purpose of the sessions, or that organisational constraints inhibited them. Since positive attitude has been seen to overcome difficulties in other situations, it is likely that this was missing to some extent within the physiotherapy group.

These three examples demand a different interpretation of the term 'bridging': the first is simply a link between two bodies of the team without necessarily ensuring an integrating outcome. The process seemed only to facilitate communication. The other two examples have been premised on incorporation; they have been a purposeful endeavour to draw other professionals into the practice of the core group. Were there any similarities in experience between the two professionals who acted in this way? The SLT had previously worked in what she felt was a highly integrated team, where joint working practices were the norm. Many of her comments about this team were reflected in the culture and practices of the rehabilitation team. Furthermore, like the rehabilitation team members, her experience had convinced her of the benefits to patients of this type of multiprofessional approach to teamwork.

The HV had worked for some time in a multiprofessional group led by social services, intended to provide better services for disadvantaged children. This had not been a particularly positive experience. However, her training had given her an understanding of herself in relation to her work, and of group process. Her work as a community HV encouraged her to be a negotiator and a collator and disseminator of information to a wide variety of professionals. This may have been sufficient; certainly such training bears similarities to that of SWs, among whom were examples of multiprofessionally-oriented professionals in the CMHTs.

7.4.4 Becoming a team member

The rehabilitation team had developed a process of incorporating newcomers which included the more usual practices of induction; meeting relevant professionals and being introduced to the structure and process of the unit. However, a major part of the initial meetings included sharing expectations; the existing team and the newcomer would discuss what they saw as their various contributions to teamwork.

Furthermore, early in their membership of the team; newcomers were expected to demonstrate their skills and knowledge in order for others to learn from them, and to express their opinions in clinical and team practice discussion. Thus the team behaved towards the newcomer as if they were a credible, accepted team member. By the same token, newcomers were expected to fit in to the team culture, to display the same open, supportive but challenging behaviour as other team members. This was a proactive method of incorporation. Was it reflected in the diabetes or child assessment teams?

This approach was the rehabilitation *team* culture, it was a *team process*. In terms of becoming a member of the diabetes or child assessment teams, a 'team' approach did not exist in this sense. One could join the team without ever becoming a member of the core group. In the course of the case studies it was possible to discuss the process of incorporation with relative newcomers, and observe their behaviour. In both these teams, newcomers recognised that becoming accepted by the core group would be their goal, since they saw that this was where their perceptions of multiprofessional teamwork could be realised.

The specialist nurse in the diabetes core group acknowledged that they had a reputation as being inward-looking and elitist. Historically they had been through a group development process which was very binding; the diabetes team was 'their baby' in many ways. Their amassed team knowledge and experience was unlikely to be shared with any latecomers, except the second specialist nurse, since the other professionals were not specialist in orientation or practice. Incorporation for newcomers was going to be difficult and possibly require more proactive work by themselves than the other way around. The dietitians realised this and had begun to make a determined effort to attend meetings and behave in a more assertive fashion with the consultant. They made a point of raising issues and suggestions with the specialist nurses. For example, they talked about having a social evening as a team, and in the face of a rather lukewarm reception, persisted. The resulting event was considered successful by them and other members of the team. In terms of trying to infiltrate this rather 'closed shop' however, one wonders how long it would be possible to maintain this type of behaviour.

Although the core group in the child assessment team was more open in terms of accepting newcomers, it did not have a cohesive approach to incorporating them, other than being a friendly group of people. This was possibly because new members would not necessarily need to become part of their group's practice. The new HV, however, was a proactive newcomer. In the eight months since her arrival in post, she had quickly made her presence felt as a like-minded professional in the following ways. First, she made it clear that she wanted to be involved by attending all case discussions. Since she was gathering information widely about a large number of children, she was able to contribute in a meaningful way. Furthermore she was able to feed back to relevant professionals in order to co-ordinate other meetings, for example. In short she made herself extremely useful to the purpose of the discussions.

Second, she regularly joined play sessions run by the playroom teacher, as a helper. This brought her into contact with other core group members and allowed her to meet parents. She would engage in conversation with parents while the other professionals worked with the children. In this way too she was able to feed back appropriate information at a later stage to core group members.

Third, her establishment of the case review system was seen by core members as a means of strengthening team interaction, and so earned the HV credibility as a '*bridge builder*'. Finally, she made a point of coming out of her office and talking to others, both in terms of *ad hoc* clinical communication, and as a social gesture. She made a great effort to become a member of the core group, and since this group's perceptions of working were similar to hers, incorporation was relatively easy.

This section has examined evidence from two teams in relation to the extent of sharing beliefs and values, and how differences can hinder team function. It has also explored issues of leadership or lack of it and how that can shape multiprofessional working, and how different

role contributions are understood in teams. Finally it discussed how individuals' awareness of teamworking processes helped them to promote better relationships between core and peripheral members, and to become incorporated into the core group. What can students learn from these group issues?

7.4.5 Learning implications

Students need to:

- appreciate the importance of the team's history and early development in providing its foundations, and how that impacts on negotiating entry into an established team; they need to reflect on the *processes of group acceptance and incorporation*, and thought should to be given to how students might be informed to seek out those who are most approachable in order to 'learn the ropes' and to raise awareness of the need for professionals to adopt a 'taking under the wing' role
- appreciate the importance to the team culture of developing and agreeing a *shared direction for practice*; this requires awareness of not only the concept of shared direction and its benefits, but an understanding that this needs to be developed through protected, regular time for reflection and discussion
- appreciate the undermining effect on team cohesion created by perceptions of: lack of role clarity, lack of reciprocity of knowledge sharing, lack of role value. There should be an understanding of the 'core' skills and knowledge which define individual professions. It is also important to develop comfort with uncertainty in the more peripheral aspects of individual professional roles. Through this, certainty of the importance one's own contribution to the team and confidence to share aspects of their knowledge and skills with others would be encouraged
- appreciate the importance of building effective communication from a foundation of informal interaction, to grasping opportunities for *ad hoc* communication and formal structured communication; they need to recognise the *different levels of communication* and the importance of each
- understand that *powerful roles within a team can undermine other's role value in the team*; communicating consistently and assertively in order to have a voice in the team is a vital skill
- address means of *integration into groups* which take account of the fact that they may not be looking outward to include new members; existing team members need to explore *how to help new members into a team* by allowing new members a voice, encouraging demonstration of skills and knowledge and providing a social forum for them to become acquainted with the team.

Section 7.5 summarises the way in which individual perceptions of multiprofessional teamwork impact on communication and role understanding within multiprofessional groups.

7.5 The individual's influence on multiprofessional working

Within both the multiprofessional groups discussed in this chapter there were professionals who shared an approach to teamwork identified in Chapter 5 as *'integrated'*. It has been seen from their beliefs and practices that a major component of this philosophy is the development of working practices in which professionals can learn from each other. The need for discussion and debate, in which it was possible to challenge the *status quo* was also an important aspect of this approach to teamwork. Only through this type of communication did professionals believe that 'team' development could occur, and the most informed decisions could be made about patient care. Both these factors were predicated on an understanding

that all members of 'the team' have an equally important contribution to patient care and that their individual perspectives bring a unique piece of the jigsaw of information and knowledge to the decision-making process.

Where individual beliefs become group beliefs, it has the *potential* to move their practice towards effective functioning, and provide identifiable benefits to patients/clients. Because different approaches to teamwork may be appropriate in different environments, this research makes no recommendation that one is necessarily a predictor of better 'hard data' patient outcomes than another. Different levels of communication and role understanding may be sufficient under different circumstances to provide effective service delivery.

However, it has also proposed that only one set of beliefs, the *integrative* approach to multiprofessional teamwork creates the potential for shared learning. This relates to an acknowledgement of the benefits of various levels of communication to patient care, where each professional is encouraged to contribute not only information about particular patients, but also insights from their experience, and reasoning from their own professional body of knowledge to decisions about care and treatment.

Shared learning also relates to a widening of professional roles; overlapping to provide a 'team role'. This allows patient care to be provided at some level by all professionals in the team, enabling them to provide continuity and consistency of care. Finally it relates to the development of a fund of 'team knowledge' about each patient. This aspect is, naturally, only appropriate in terms of long-term patient management such as elderly care, rehabilitation, and care of the chronically ill.

This chapter has demonstrated that some team members did not share this approach to teamwork, either because of assumptions that they would *direct* the team's activities, or that they *elected* to remain separate from team involvement to the same extent. In these cases mismatches were seen in the levels of communication and the depth of role understanding. Why was this?

Taking the *directive* approach to multiprofessional teamwork first, superficially this may entail a shared set of beliefs about communication and role understanding. Furthermore, these may lead to similar outcomes for patient care. However, because of the nature of this approach, in which one person directed the decision-making process and has the power to control communication made by others in the group, it was potentially limiting to professional input. In addition, because there seemed to be a different interpretation of role, that is that the person directing the team may assign value to the tasks rather than the rationale for action, this approach could be considered as professionally undermining. Role overlapping may have occurred, but could be seen as 'helping out' by those directing, and to some extent in the gift of the 'helper', rather than a systematic pattern of role extension. Finally, because of the hierarchical nature of this approach, although professionals may have learned from others, it was more likely to be 'top down' than 'bottom up', which precluded others from having the opportunity to share their knowledge and experiences.

Those who shared a belief in an *elective* approach did not seem to fit a concept of multiprofessional *teamworking* since essentially it appeared inward-looking in its relationship with the patient/client. Communication between the professional and others in the team could be informative but not generally discursive. Challenge may not have been seen as appropriate because of the acceptance that each professional provides their own particular contribution from a standpoint of role clarity and confidence. This approach promoted a sense of professional worth, but, because of its perception of the need for impermeable role boundaries, one that did not accommodate change readily. Therefore, as in the directive approach, the opportunities for learning between 'elective' professionals and other team members were limited.

In relation to beliefs about multiprofessional teamworking, the main challenge is where individuals hold different concepts. This has potentially detrimental outcomes in terms

of what is communicated and to what depth. For those who believe that they should communicate at all levels rather than that encouraged by either a directive or elective approach, this is not only frustrating to the professional concerned, but also interpreted as showing a lack of valuing for their contribution. It can also be perceived as threatening the decision-making process since all perspectives are not given equal weight.

A second area of conflict was in terms of the mismatching of interpretations about role contribution. This related to the need to understand the role components: how is the role demonstrated, what is the rationale behind it, and what can be learned about the skills and knowledge that make up the role? Outcomes from these mismatches could be detrimental to both professionals and patients. For professionals working in a multiprofessional context and wanting to engage in all these levels of understanding, an emphasis from another professional on only *what a person does*, rather than *why they do it*, could again be seen to deny the value of their professional contribution. In terms of patient care it could lead to professionals conducting their input along parallel lines, either duplicating input, or providing conflicting input.

However, as might be expected, via the professional socialisation process, there was a cultural component to belief systems. Many doctors held a directive philosophy, and many of those involved in psychological therapeutic intervention held an elective philosophy. Although this was not necessarily exclusive, it was difficult to determine why those exceptions occurred. Possibly the environment was a factor, those high-status professionals working in areas such as paediatrics, elderly care, and rehabilitation may be less concerned about power relationships than others. Possibly gender was a factor; those in high-status positions who did not assign to a directive philosophy were all women. However, it may well have been prior experience of working at a different level in a multiprofessional group in which a collaborative approach was the norm, since experience of this type of 'teamworking' was seen to provide strong motivation to see it perpetrated elsewhere.

The mismatching of individual perceptions about multiprofessional teamwork seem to be an important factor in terms of 'team development'. It is one thing to define multiprofessional working in terms of its patient/client focus; it seems that it also needs to be defined in terms of a shared understanding of the phrase 'multiprofessional teamwork'. Students coming into the health professions need to develop an understanding of how those different perceptions could shape professional relationships, and where possible how strategies related to communication could help to minimise the effects.

7.5.1 Learning implications

Students need to:

- understand the value of those in the team who bridge communication gaps between its members whose communication style inhibits professional input from all team members equally
- understand the importance of congruence across the team, that different professional groups should share an understanding of how effective multiprofessional teamworking is achieved, in order to encourage a consistent approach to client management; where this does not occur, team function is compromised and patient/client care can be detrimentally affected
- appreciate the contribution of prior learning, which enables team members to be proactive in generating ideas to facilitate more effective working. They need to be aware of differences between offering new ideas based on a monoprofessional perspective, and new ideas about multiprofessional frameworks; the means and timing of presentation. In addition students need to understand the varying impact of new ideas and working methods and how they are incorporated within well established teams.

7.6 Conclusions

Chapters 5, 6, and 7 described and discussed three types of multiprofessional working where different levels of collaboration were identified. The benefits to patients as a result of more collaborative working were clearly seen, and it was possible to determine the compromising effect of more fragmented patterns of care. The chapters raise four further issues. First, how widespread are the type of collaborative practices seen in the case studies? Second, how easy would it be for professionals who had worked in teams where collaborative practices were the norm to pursue them in other, less collaborative teams? Third, what does this imply for powerful, high-status members of the team? Finally, what does this say about the ways in which trusts support multiprofessional working, if as suggested earlier, it is to the forefront of organisational rhetoric?

7.6.1 The prevalence of collaborative practice

It could be argued that interactive, collaborative teamwork is unusual. Since only one team among the six case studies showed a high level of multiprofessional collaboration, this type of working may be rare. (While no claims can be made for the teams studied being typical, there is enough in the literature, see Chapter 2, to suggest that the case studies are not unusual. Furthermore, the concepts derived from studying team processes can still be relevant and applicable to other teams. One test is whether they present 'recognisable reality' to others.) First, organisational factors such as stability and predictability, designation of professionals to the specialism and lack of external priorities for staff, supported this type of working. Second, the team operated without a medical model or major medical input. What would be the likelihood of students encountering collaborative multiprofessional practices in the more turbulent acute services, or even in community services where workload demands may be more intense and diverse?

In the acute sector, where organisational policies have driven working practices towards greater patient turnover by filling as many beds as possible, and staff turnover is high, despite good intentions, the development of highly collaborative working practices may be practically impossible. The medical ward may well be representative of such acute services and there, many professionals were limited to 'surviving' the vicissitudes of the organisation on a day-to-day basis rather than attending to the idea of multiprofessional team development (although as was seen in Chapter 3, some trusts have taken steps to overcome some organisational barriers to teamworking).

Where more stable and predictable environments exist, such as in the teams where core and periphery working was prevalent, other factors combined to make *whole team* collaboration hard to achieve. Having no whole team focus in terms of patient care, some members being subject to other prioritisation outside the team, and having separate management structures which were not in communication, all divided team members. Furthermore, one of these teams was required to work across two trusts and outside agencies, which created problems with mismatching policies and procedures.

If collaborative practice is the exception rather than the norm, how would professionals fare who have worked in a collaborative environment and then move to a 'team' which does not function in such a manner?

7.6.2 The transfer of collaborative practice

One research objective had been to explore with team members in each case study how prior experiences of multiprofessional practices influenced working in future teams. In the rehabilitation unit, where professionals such as the PT and OT heads of department came into the team, it was possible for them to apply the prior knowledge and skills they had developed in team-working. For the PT, her understanding of the benefits of collaborative note-keeping enabled the development of this approach in the 'new' team. For the OT, her knowledge of the

use of Bobath principles as applied to OT practice were disseminated to other OTs and resulted in greater compatibility between the OT and PT approaches to the care process.

However, both this chapter and Chapter 6 also noted the problems experienced by two professionals who tried to bring prior positive learning about multiprofessional teamwork into their current, less collaborative teams. Both group and organisational issues made the transfer of their teamwork skills and knowledge difficult to achieve. The problems lay not in terms of the professionals' motivation to pursue this type of working, but in terms of either *the reception of such ideas about team-working*, or the *overarching organisational structures and processes* which inhibited the setting up of such patterns of work, or a combination of both.

For the OT from the CMHT in Chapter 6, her enthusiasm and motivation for teamworking was unable to be expressed because of the lack of openness to the concepts in her new team. For the SLT from the child development assessment team in this chapter, her ideas had been accepted and had changed some professionals' practice in the team. However, her message fell on stony ground for other professionals, partly because of the organisational context. These examples raise an important issue not only for the transfer of collaborative practices among professionals, but also for the development of student education which might seek to promote multiprofessional working.

The two professionals identified above had developed an awareness of the benefits which this working could provide to patients and professionals alike, and were keen to promote the same working in their current teams. They felt that they understood what was required in terms of facilitative structures and processes, and discussed such issues with other team members. However, describing what could be achieved through this pattern of working, and how to change and develop practices to support it did not appear to have sufficient impact to promote its development. Why? Several possibilities could be put forward. First, the promulgation of a convincing argument for change takes dedicated time for team members to explore and develop understanding of new practices. Second, there would need to be a sufficiently large number of professionals within the team who were open to the proposition and in a powerful enough position to be able to execute a change process. Third, power could also *inhibit* change; in a situation where several members were prepared to change, but those in positions of power in the team were not, moving practice on may be a lost cause. Remembering the powerful *positive* influence of the leader of the rehabilitation team, it is easy to see how this influence could also work negatively. Fourth, establishing change processes takes a great deal of attention and pursuit; this extra effort on the part of the change agent may not be possible within a busy working environment.

Finally, in terms of constraining organisational structures and processes, it was clear from the child development assessment study for example, that working across different trusts as was problematic in pursuing change. Where policies did not match, or management from the different trusts were not in communication, ideas were stillborn and opportunities were lost.

The implication is that professionals would need to be supported by a 'collaboration-friendly context' to use their prior experiences in that setting. This discussion also has implications for those who may in future be educated in a multiprofessional approach. How would they as new and junior members of a team influence others to alter their practices? For *students* coming into a clinical setting, their chances of maintaining the motivation and skills to promote multiprofessional teamwork may be more readily lost, since they would lack confidence and credibility.

In terms of the transfer of collaborative practices therefore, two problematic areas have been identified: power and status of some team members, and the organisational context. From the case studies, it was clear that collaborative working practices did not sit well with some members of the medical profession. Section 7.6.3 discusses the implications of this finding.

7.6.3 What are the implications for the medical profession?

The case studies illustrated that unless doctors are willing to engage in genuinely collaborative teamwork, it will not happen. Nurses may represent the largest number of clinical staff in the NHS, but it is universally acknowledged that the dominant professional group is the medical profession. Soothill et al. (1995: 8) say for example:

> *'Doctors enjoy undoubted supremacy in the management and direction of the health care team. Without doctors' goodwill to listen, the contributions of other professionals can be marginalised. Interprofessional working, in other words, is a question of the redistribution of power in health care. Other than in the interests of patients, there seems little reason why doctors should acceded to demands to power-share. Why should one professional group embark on a process of decision making which reduces its power and makes decision making a slower and more laborious process?'*

Soothill and colleagues believe that changes in the NHS will compel doctors to change. Government initiatives to improve efficiency and value for money, changes in the management structure and the type and style of manager, and pressures for accountability (currently manifest in clinical governance) will all tend to diminish 'medical supremacy'. Yet, as they identify, these changes and pressures might indicate that this is the worst time to bring in further changes in working practices. More optimistically they comment that attempts to improve interprofessional collaboration and teamworking *'may well be the antidote to the disorienting changes in the NHS'* Soothill et al. (1995: 10) as different professionals come together in adversity. From the case studies this has yet to happen, indeed what has been observed more frequently is people striving to maintain the *status quo* in times of stress.

Bed-management policies, resulting in a spread of working across many wards in acute care, heavy workloads and shortages of staff, militate against interprofessional teamwork. However, it is possible that new policies such as integrated care, practised by closely collaborative teams, would be effective in bolstering morale, assuming the will is there. This is a crucial point. Chapter 3 demonstrated that some members of the medical profession had sabotaged the instigation of care pathways for example, by opting out of the evolution of the process. How to bring unwilling professionals into the collaborative arena is a dilemma for managers. Yet, the various professional bodies, including the General Medical Council (in a response to the research team) seem to support the notion of collaborative working:

> *'We believe that making the best possible use of the skills and abilities of both doctors and nurses contributes significantly to good patient care and the effective use of resources. These objectives can be achieved only where all professionals work together and understand and respect each other's roles and abilities. Indeed we have already taken some steps towards encouraging doctors to work constructively with nurses. We believe that good interprofessional relationships should be established as early as possible in the training of doctors and this is reflected in our guidance Tomorrow's Doctors and the New Doctor.'*

This recommendation for medical training seems helpful, however, more radical steps may need to be taken to encourage medical students to understand other professional perspectives and rationales more comprehensively, and to enhance their willingness to listen to others' input. It is possible that their inclusion in a shared learning process with other professional groups, as part of their initial education, could produce these outcomes.

7.6.4 How are trusts supporting collaborative working?

From the case studies there are also clear messages for trusts wishing to see multiprofessional teamwork develop effectively in their organisations.

Although as suggested above, the fostering of motivation to pursue collaborative practices in teams seems to be largely related to addressing attitudes and group dynamics, the organisational context is equally important. As pointed out by managers in Chapter 3, the reality of managing trusts with limited money and manpower has created a situation which seems to undermine collaborative multiprofessional working in some areas. This was recognised by several managers and indeed some trusts have attempted to redress the outcomes of earlier changes to structure and process.

Notions such as a return to ward-based professionals and multiprofessional practice boards are in their early stages of development, and patchy in terms of spread across trusts. However, if, as the message from trusts, and particularly from representatives on education consortia, suggests, multiprofessional teamworking is high on the agenda, then scrutiny of, and modification to, structure and process appear to be fundamental to the success of such a drive. No matter how supportive to multiprofessional teamworking professional education becomes, it would be only dealing with half the equation if students then faced a culture that is hostile to such practice.

Chapter 8 explores further the learning implications that evidence from the clinical settings provided, and offers suggestions as to how students could best be prepared to work effectively with other professionals.

Key points

- Specific strategies and levels of multiprofessional learning are appropriate to each of several stages in the life of the developing professional.
- Teachers need to challenge students' professional stereotypes early in the education process.
- Students need to discover their professional identity and feel more secure in their skills and knowledge before they can participate fully in a multiprofessional learning context.
- Later stages of the learning process may best be served by the provision of multiprofessional, small group, problem-based learning, so that students may:
  - develop an awareness of other professionals' contribution, and the underpinnings of their actions
  - recognise the dependence of each profession on appropriate interprofessional communication and referral
  - develop the skill of challenge within a multiprofessional context, in order to later achieve representation in a team decision-making process
  - understand the advantages of, and need for role flexibility within a multiprofessional context
  - discover the benefits of multiprofessional interaction for patient care.
- Multiprofessional learning should be an ongoing process in the clinical and classroom setting.
- Students need to develop an understanding of, and strategies for existing in, a fluid organisational context.
- The variable quality of multiprofessional teamworking demands that students be taught the skills to maximise their own effectiveness in fragmented environments as well as collaborative environments.
- Where appropriate, post-qualification learning about multiprofessional working could be part of a whole team activity, exploring all aspects of team function.

8.1 Introduction

Whether or not health care professionals are involved in multiprofessional teamwork, almost all work within a multiprofessional context, from junior students to senior managers. Although students may focus on developing comfort and competence in their monoprofessional role, it will almost certainly involve contact with other professions, which may reinforce or modify stereotypes of their own and other professions. Typical student experience exposes them to a series of environments and teams, offering opportunities for learning about teamwork, but requiring the early provision of tools to enable them effectively to use those opportunities.

Their short involvement means students may only gain 'affiliate' status in a multiprofessional team, but after qualifying, they have the opportunity to become more fully involved. Taking that opportunity involves developing their teamworking skills, including team building and involving new members. Senior managers are likely to be in close contact with other professions at an institutional level, but also need to provide an organisational culture in which effective multiprofessional working can thrive. The agenda for learning about multiprofessional teamwork therefore spans the whole of professional education. This section

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CHAPTER 8 looks at the multiprofessional teamwork agenda as it relates to professionals during initial education and on qualification:

- the pre-clinical student: the student who has not yet undertaken any clinical experience
- the clinical novice: the student moving into and becoming familiar with clinical learning for the first time
- the probationer: the senior student or 'intern' who is familiar with the clinical environment, but not yet 'resident' in a particular clinical environment
- the practitioner: the qualified professional practising in a particular clinical environment, with a commitment to and accountability for standards of care.

Differences in professional education and in individual experience and learning means that students and new professionals will vary in the stage at which they move from one category to another. Having looked at education focusing on these professional development milestones, the chapter then considers the role of:

- whole-team learning activities involving professionals over a range of career stages
- the professional leader, a senior member of staff with responsibilities for developing or enabling the development of effective teamwork.

8.2 The stages of professional development

8.2.1 Pre-clinical learning

Since this chapter considers the implications of the clinical case studies for education, it focuses on the clinical stages of professional learning. Students of some professions (e.g. medicine) may have a substantial pre-clinical component to their education, but most students from all professions have a period of 'classroom' preparation.

Although lack of clinical experience restricts the topics which can be tackled through multiprofessional learning, it does not negate the value of shared learning, in which contact with other professions exposes students to different attitudes or priorities. Students enter the professions with different educational backgrounds and, during their pre-clinical education, undertake different learning; however, these contrasts are unlikely to offer an appropriate focus for shared learning.

Students do not enter programmes of education with an undifferentiated perspective on health care and its professions; they will already have perceptions based on their own or family contact and media portrayals. In selecting a profession, they will have accepted some of that profession's attitudes, including its view of itself and of other groups. Exploring these attitudes can therefore start before any patient contact takes place.

8.2.2 The clinical novice

This section looks at the multiprofessional teamwork agenda as it relates to students who are new to the clinical environment and clinical learning. In nursing, this may relate to students within a few weeks of commencing their education, while in the medical school, students may be in their third year of study. Students at this stage judge the relevance of learning within a narrow frame of reference defined by their own expectations and those of others in relation to their role (e.g. Lucas, 1990; Funnell et al., 1992). Since they are still developing their basic competence and making sense of their professional identity, they have little interest in other professions. However, they are constantly exposed to the multiprofessional context of health care, undertaking learning relevant to that context, collecting information about it and developing a perspective towards it.

Learning takes place in the theory or practice setting and may involve formal teaching, exposure to influential others within their own profession and direct observation. Considering

the 'own profession' focus of new students, what, if any, formal teaching about multiprofessional teamwork will resonate sufficiently to enable quality learning? And what formal teaching will be equally appropriate as preparation for multiprofessional teamwork?

It is tempting to suggest that no formal teaching should take place on the multiprofessional context until students have developed an appropriate level of comfort in their own professional role. However, students are constantly learning about other professions: a student nurse working with a staff nurse on the ward will learn about:

- the interface between their role and those of other professions: *'We are giving this drug now because the doctor has ordered on the drug chart'*
- how their profession views another profession: *'Typical! We can't give the drug because the doctor hasn't filled in the drug chart'*
- how their profession is viewed by another: *'You know the consultant always gives this antibiotic post-operatively, so why did you get me out of bed to rewrite the drug chart?'*

Through such interactions, and more explicit passing on of prejudices, students develop a view of health care professions and their station within the hierarchy (Stroebe and Insko, 1989). The interactions are likely to prove fertile ground for such learning, since students enter professional education with stereotypes; the longer these stereotypes are reinforced without challenge, the harder they may be to tackle. Even if new students are not ready to learn about active involvement in multiprofessional working, action would be needed to ensure that they reach the point where this learning *is* relevant with positive professional stereotypes, or at least an open mind. This may be facilitated in the longer term by improving multiprofessional working in environments to which students are exposed, so that stereotypes are challenged. It may also be facilitated by early social contact between students from different professions, although there is always a danger that this may simply confirm stereotypes.

Brief formal teaching outlining each profession's role and focusing on the interface and overlap at role boundaries may be appropriate. More importantly, students may benefit from opportunities to uncover and explore stereotypes and their origins. This is likely to involve recognition of the truth in the stereotype, as well as the misrepresentation (Stroebe and Insko, 1989). By making these stereotypes explicit at an early stage in professional development, students may be encouraged to think more critically about received perspectives from fellow professionals, and the way in which they observe others. Such interactive learning opportunities are probably only possible within a multiprofessional learning group but, as suggested earlier, aspects of teamwork may also be met through monoprofessional learning.

The case studies identified a number of teamworking concepts and skills with which students need to become familiar; in some cases, the implication is that this should be achieved as early as possible. How can this be squared with students' apparent reluctance to move towards a multiprofessional agenda? Although the concepts and skills are raised by the case studies in the context of the multiprofessional team, some are equally relevant to monoprofessional teamwork. Students see considerable differences in monoprofessional teams to which they are exposed, both in relation to structure and philosophy: e.g. those created by democratic, authoritarian or *laissez-faire* leaders (Lippett and White, 1958). This allows them to reflect on the rationale for and effect of different strategies long before they are in a position to consider types of multiprofessional team (Øvretveit, 1996).

The monoprofessional team can not be excised from its multiprofessional context, and students will be exposed to considerable differences in role boundaries. If explored rather than simply experienced, students may develop a more positive view of the differences in role boundaries. Rather than being a source of confusion, a comparison between role and role boundaries may enable students to identify the fluid periphery and, by differentiation, the core professional role.

One skill which the case studies showed that students need to develop as early as possible is that of gaining acceptance and incorporation into a team. Again, this is just as true of a monoprofessional team as a multiprofessional team. Students can therefore benefit from developing team entry strategies before their first clinical experience. At this stage, institutionally driven mentoring systems are particularly important, since new students are in greatest need of someone to take them under their wing, but least able to choose an appropriate mentor.

Other aspects of the value of multiprofessional teamworking may be better taught during this monoprofessional stage, as they support multiprofessional working, but also relate to the need of an individual profession. The case studies suggest that assertiveness training may be important for groups such as nurses, who see themselves as less powerful within a multiprofessional team. However, observation of patterns of communication within medical teams (Sinclair, 1997) suggests that junior entrants to 'high status' monoprofessional teams may also need assertiveness training. Although this need might be universal, differentials between the status of groups of junior students suggests that training might be better managed monoprofessionally.

If the agenda outlined above were followed, new students should enter the senior stages of initial education better equipped to move to a multiprofessional learning focus. They should be less burdened by professional stereotypes; have a clearer perception of the permanent core and fluid periphery of their professional role and have a clearer view of teamworking models. Further, they would have the communication and interpersonal skills to gain acceptance within the multiprofessional team and to make an effective contribution.

8.2.3 The probationer

Within the loose categorisation suggested earlier in this chapter, probationers may be defined as senior students who have sufficient clinical experience to have developed a degree of comfort with their professional role, but are still required to undertake set clinical learning in a number of areas. Responsibility and accountability are limited. Commitment to a particular area is also likely to be limited by the transient nature of probationers' presence and the fact that experiences are allocated rather than selected.

The sophistication and accuracy of insight into the roles and behaviours of other professions may depend on the curriculum in the early part of the programme of education, but senior students will have had ample opportunity to observe other professions in the clinical area and have interacted with other professions through their own clinical activity.

Although students from different professions will have had contact, this is likely to have related to specific tasks, undertaken under instruction from more senior members of their profession. As they are still focused on their own professional activity (Miller et al., 1998), students are unlikely to have given much thought to:

- the appropriateness of the expectations one profession appears to hold of another
- the part played by other professions in the intervention
- conflicts that may arise from different professional perspectives
- the most appropriate strategies for agreeing and co-ordinating multiprofessional activity.

As the case studies suggested, this is an important agenda. Qualifying professionals are soon required to represent their profession in multiprofessional negotiation. It is therefore an appropriate agenda for later years of initial education. Without encouragement, students are unlikely to prepare for their role in the multiprofessional world. In the best team environments, this encouragement may happen automatically, through involvement in effective teamworking strategies; however, exposure to such teams cannot be guaranteed, and a more planned approach is therefore necessary.

Appropriate approaches could be expected to revolve around an interplay between classroom and clinical environments. Senior students will have sufficient experience of monoprofessional working to bring a realistic professional perspective to problems posed in the classroom. They are therefore in a position to tackle case- or problem-based learning designed to focus attention on the interaction between professions and the development of effective tactics for resolving conflicts and getting the best from the multiprofessional team. In comparison with the clinical environment, classroom learning may provide greater opportunity to explore the rationale underpinning a particular professional action, rather than simply surface behaviours. This in turn allows students to explore the knowledge base and philosophy of other professions. Clearly, problems/cases need to be relevant to all students involved in their consideration (Areskog, 1991; Knowles, 1984). Since students are using their monoprofessional experience as the basis for working on such problems, they should not relate to types of clinical area where they have not worked, but should offer students the opportunity to work together (Silver, 1998) and contribute meaningfully to their solution.

The case studies suggested that problem-based learning might be sequenced to manage students' route through this complex agenda. They may start with problems where professional roles are clear and compatible, focusing on appropriate patterns of interprofessional communication; after this, problems where there is some question of which profession does what will allow students to explore conflicts over role boundaries. Later they may tackle problems where the perspective of the various professions would lead them to favour different interventions.

The understanding developed through these classroom processes can then be used in the clinical area, sensitising students to multiprofessional issues, enabling them to observe multiprofessional practices with a more intelligent eye and to engage more competently with other professions on an individual level. In terms of gaining acceptance within the team, senior students are better placed than their junior colleagues because of the more even balance of service workload undertaken and supervision workload created for qualified staff (Cerinus and Furguson, 1994). Although gaining entry still means finding an appropriate sponsor within the team, their relationship should be more even. By the end of initial education, students may be required to find this mentor for themselves, a skill which will be vital to their continuing professional development.

Senior students are also in the best position to explore team models and strategies through reflection on practice. Compared with junior colleagues, their eyes are more open to the activities of the multiprofessional team. Unlike qualified staff, they are exposed to a number of teams and can compare and contrast them.

Students' exploration of teamwork and the differences in structure and process of the teams through which they pass, will undoubtedly raise questions about how teams are shaped by their organisational context. The understanding they develop will make them more constructively critical of patterns of teamwork encountered in new environments. Understanding the organisational constraints within which the new team functions may make it easier for students to recognise which teamworking strategies they have developed through past experiences can be appropriately utilised in the new environment. In a conducive environment this might involve sharing collaborative strategies which they have found useful elsewhere. In a less conducive environment, it might mean invoking strategies that would at least ensure that they use any opportunities they find for multiprofessional interaction: we are not advocating students acting as change agents.

Within team-orientated clinical environments, students may be exposed to joint working practices such as shared notes and joint planning and evaluation. In the current climate, such an opportunity cannot be guaranteed, and group reflection allows students who have had such an experience to share their learning with others. A discussion of the effects of such approaches and the way they are applied can give students an array of tools to take into their professional role.

8.2.4 The practitioner

The new professional, in becoming a long-term member of the workforce in a clinical area, faces a massive change in role and responsibilities. Although students train for their qualified role for anything from three to five years, many still experience considerable 'future shock' on leaving the relative protection of student or probationer status. This relates to new roles they are required to fulfil and to the new context of accountability within which they must fulfil these roles (Sinclair, 1997). Newly-qualified professionals may, therefore, feel a reduction in confidence and competence.

For the first time, new professionals are stable members of a clinical environment and have an opportunity to take up full membership of a multiprofessional team. This is gained in their own right as individual professionals, as opposed to the associate membership granted through membership of their profession. Although team membership is now possible, it is not achieved automatically on qualification. As demonstrated by the case studies, it depends on the team and individual concerned.

Some teams appear more reluctant than others to allow new staff full entry. A sense of trust between existing members may have developed through a shared history that cannot be experienced by newcomers. Such shared experience also leads to the development of a communication shorthand which further excludes newcomers. In these situations, the difficulty experienced by the newcomer is, to some extent, the result of the cohesion of the existing team; in other situations it is the result of lack of cohesion.

Cliques within a team make life difficult for newcomers, and their selection of a mentor may make the difference between acceptance and non-acceptance. In other areas, professionals may lack the strategies to include new members effectively. Where such difficulties are long-standing, team function is likely to suffer: turnover is likely to be high and the team may consist of a number of 'generations' of unassimilated newcomers. Such groups require the development of joint philosophies and working practices; the means for achieving are discussed later.

Where existing professionals in a clinical area can be termed a team, new professionals need to refine and reapply skills developed as students (gaining associate membership of a monoprofessional team) and develop new ones related to full membership of monoprofessional and multiprofessional teams. The degree to which such skills are necessary will, to some extent, be determined by the degree of facilitation available, but they are always valuable. A team that needs to expend less energy in drawing in a new member is bound to be more positively disposed towards him or her.

For the first time, new professionals are likely to be in a clinical team long enough to experience change processes within the team, rather than differences between teams.

The case studies suggest that team members need help to come to terms with this personal change, especially if it is perceived as change in professional roles or role boundaries. There may be advantages to such help being provided within the team, since other members will be aware of external and internal factors relating to the change process and are likely to be party to negotiation over changing boundaries. Indeed, where such facilitation is not possible internally, it might suggest a need for whole team learning in relation to managing and coping with role change.

While assertiveness training may be important throughout initial education, this relates as much to functioning within the monoprofessional hierarchy as to multiprofessional activity. Newly-qualified professionals need to reapply assertiveness skills in an apparently more threatening context. Current patterns of staffing mean that in many clinical areas new professionals are unlikely to have the peer group support they enjoyed as students, or the back-up of a more experienced member of their profession. They may be in a position where they have to communicate across considerable variation in seniority *and* the hierarchy of the

professions. New learning in relation to assertiveness is likely to be necessary for newly-qualified nurses dealing with senior doctors, but is also likely to be valued by junior doctors, who may feel vulnerable in dealing with senior nurses. Such learning may well be best provided outside a new professional's clinical area in a safe environment where they can test and refine communication strategies without endangering long-term relationships.

Additional learning in relation to joint working practices and the development of common philosophies is vital to new professionals. Although the perceived advantages of joint practices may be taught didactically in the classroom, specific joint practices and common philosophies must be developed within the context of a specific team, to take account of the physical resource, client base and mix of professions involved.

Where a multiprofessional team has well-developed shared philosophies and joint practices, the case studies showed that these were likely to be effectively transmitted to newcomers. However, where existing members excluded newcomers from 'full communion', the transmission of a team philosophy could not be guaranteed Where there is a need for development of a shared philosophy and effective joint working practices, a process of whole team learning is likely to be appropriate.

8.2.5 Whole team learning

Each individual in a multiprofessional team may usefully develop and bring to the team an understanding of other professionals and their roles, a raft of teamworking skills, and attitudes which foster appropriate interaction. Whether or not such learning becomes the norm, the case studies suggest that a further level of teamworking development can valuably be undertaken as part of a whole team learning process.

An important aspect of the multiprofessional teamwork learning agenda suggested by the case studies relates to the development of shared strategies for clinical interventions and for professional interaction and joint practices in relation to note-keeping, handover procedures etc. Whole team learning strategies, in which all staff are involved, are an ideal means of meeting this agenda, allowing learning to focus on the specific clinical context. Interprofessional communication can therefore be taught in the context of everyday reality rather than as an abstract concept, and the development of joint working practices can take effective account of specific constraints and opportunities. Furthermore, the shared learning process prefigures the desired team process. When the intention is to shift what may be deeply entrenched attitudes, the learning process must be appropriate (Jarvis, 1988; Long, 1996).

Where do whole team learning processes take place? Clearly the material for much of the learning is in the clinical area. Current practices, both satisfactory and unsatisfactory, can provide a springboard for the continuing development of best teamwork practice. Poor practices may provide evidence of preventable patient care problems or missed opportunities, while satisfactory practices may highlight new opportunities for the continuing consolidation and enhancement of teamwork.

Whether an issue needs to be brought to the attention of the whole team by an individual profession, or is recognised by the whole team, there may therefore be advantages to considering it outside the clinical area. Professionals can make sense of clinical experience through reflective learning (Palmer et al., 1994): while members of different professions may have different perceptions of any given clinical event, group reflection can help a team to share those perceptions and identify a common way forward, whether in shared strategies, joint practices or changed behaviours.

Individuals who are familiar with reflection and are part of a group that is functioning well may be able to participate in group learning processes without facilitation. When considering non-contentious issues, facilitation may be provided by a member of the team with the necessary skills to maintain an even-handed approach. However, for many group learning issues external

facilitation may be needed. For example: where a powerful individual from a high-status profession is reluctant to recognise a need for change, internal group leadership may be problematic. If that individual is also the team leader, the need for change may not reach the agenda. Where professions are in conflict, an external facilitator may be seen as an impartial referee able to achieve resolution when an internal leader would be seen as an interested party. An external facilitator may also encourage those professionals who are not raising issues and challenging others to take a more active part in the group process.

The design of whole team learning strategies, including decisions about the need for external facilitation, must take on board the entry behaviour of each profession: the degree to which each is signed up to the idea that joint approaches and working practices are desirable and should be achieved by democratic means. It is easy to bring to mind situations in which joint working strategies are desired by some professions and rejected by others. Unless the dissenters are brought on board, the best that can be achieved is joint working among part of the team. Depending on the power of the objecting profession, it may overtly veto the development or covertly undermine it. If a belief in common purpose and direction is part of the definition of a team, whole team learning must facilitate this before moving on to a more substantive agenda.

There is also an assumption that the *individuals* concerned in whole team learning are able to cast aside any constraints on communication, interaction and decision-making within the clinical area. As identified within the case studies, constraints may relate to the comparative status of the various professions, individuals' comparative status within a profession, or their status within a team. Constraints may also relate to a perceived risk in scrutinising specific clinical actions and decisions. It may be valuable to consider how such constraints could be affected by:

- proximity of the learning environment to the clinical workplace
- the 'ownership' of the learning environment
- the organisation of learning as part of, or separate from, a clinical shift
- the organisation of learning in terms of a whole study day or 'the odd hour'
- making whole team learning a 'uniform' or 'mufti' activity.

There are organisational constraints on whole team learning in most secondary care situations created by the impossibility of closing a seven-day service to enable all team members to attend together. This is likely to mean that individual members can only be involved serially in any learning/development process. While many processes will, in any case, take place through a series of events, care must be taken to avoid the potential problems created by inconsistent attendance.

Senior professionals form the interface between the clinical team and the organisation, representing each entity to the other, and have a vital role in both encouraging and enabling the development of effective teamwork. Much of their role within the clinical team is about facilitation and leadership in achieving the learning agenda identified within this and previous sections. Preparation for leadership in these processes suggests additional learning process to those already described, if not different content.

8.2.6 The professional leader

Senior members of any profession have a responsibility in relation to the development of team processes. They are the key change agents with considerable influence over junior staff in terms of the role model they present, the professional opinions they offer, and their organisational position and decisions. Successful multiprofessional teams often rely on a high-level sponsor to lead the process: in the rehabilitation unit case study for example, the importance of the unit manager was paramount.

Senior management programmes will therefore need to alert leaders to issues relating to their role in creating a fertile environment for the development of multiprofessional teamworking and ways of responding constructively to initiatives developed on the 'shop floor'.

Management issues raised by multiprofessional working will generally have a monoprofessional counterpart. Creating an appropriate environment for the development of multiprofessional teamworking will share many facets of creating a fertile environment for teaching students, for clinical audit, or for the introduction of named nurses. In the same way, the ability to respond to initiatives from the shop floor is largely about management style.

The required change in senior management programmes would therefore be a reframing of existing content to reflect the increasingly multiprofessional environment of health and social care. This would require the same awareness of other professions as discussed in relation to the probationer and the practitioner, focusing on the organisational and management context within which each profession works.

The case-based learning described in relation to earlier stages of professional development could be equally effective at this level, except that the 'case' might relate to the implementation of an organisational policy or promotion of an initiative arising from one profession but requiring wider collaboration.

Undertaking such learning in small multiprofessional groups, in which members of each profession 'play themselves' in the safe context of simulation, provides an opportunity to practise negotiating skills, maintaining an appropriate balance between fighting their professional corner and working flexibly. It enables the development of an understanding of how managers of different professions feel enabled or constrained by the organisational context and their own professional bodies. Simulating or modelling alternative patterns of multiprofessional working can be a learning tool for the organisation as well as for the individual, providing a vehicle for the consideration of service decisions in which risks may be taken with limited consequence and in which less constrained thinking may therefore be safely employed.

If members of all professions were developing through the staged framework described in this chapter, there might be little need to specify formal multiprofessional learning for senior managers, since it could be assumed that they had already reached the necessary interprofessional empathy. However, waiting for those 'changed' professionals to rise through the ranks is not an option. If the organisational context fails to encourage collaborative working, the learning which should support multiprofessional working may have been extinguished before they reach levels of influence. Multiprofessional learning at a management level might therefore valuably precede the implementation of learning at more junior levels. Much of the teaching and learning of senior professionals already takes place in small, multiprofessional groups, and a shift in focus from common learning (we all need to learn the same thing) towards shared learning (we can all learn from each other) should be achievable and effective.

This chapter has identified potential for education to facilitate the development of multiprofessional working. The agenda is broad and informs both initial and continuing education in all health and social care professions. This suggests a high degree of co-ordination between the professions, health care providers and educational institutions; the extent to which this co-ordination exists is discussed in Chapter 9.

Key points

- Little multiprofessional education revealed in a survey of educational institutions addressed the interprofessional issues suggested by the NHS agenda.
- The survey identified 206 initiatives, 68% post-qualification and 32% pre-qualification. Of these, detailed responses were provided for 95.
- In continuing professional education the major shared learning areas were clinical intervention and research.
- In initial education shared learning was predominantly in biological and behavioural sciences, taught in large groups through lectures.
- Flexibility and economic considerations were the main drivers for shared learning in universities.
- NHS and higher education agendas were pushing in opposite directions; the former towards small-group, interactive learning, the latter towards didactic lectures.
- Organisational barriers to shared learning were: timetabling, different cohort sizes, timing, and loss of specialist content.
- 'Teamwork' was not a popular aspect of initial education curricula; acquisition of clinical knowledge and skills was more important to students.
- Programme leaders did not identify barriers to shared learning as coming from professional bodies. This was congruent with data from professional bodies which supported shared learning.

9.1 Introduction

The clinical case studies provided a clear picture of the varying and vital nature of teamwork in multiprofessional practice and the experiential learning which helped to shape it. They also provided an insight into the potential role of formal education in enabling professionals to work together more effectively.

Multiprofessional teamwork in clinical areas provides an agenda for education, but education is shaped by competing and sometimes conflicting factors. Each set of circumstances is different and educational solutions must take account of the differences; it would therefore be inappropriate to try to identify a single ideal model. However, it is possible to identify characteristics which would enhance a programme's value and facilitate learning that could not otherwise be achieved.

The clinical teamwork agenda has implications for both:

- the appropriate content of multiprofessional learning
- the nature of the teaching and learning strategies employed.

9.1.1 The content of multiprofessional education

The nature of much of the educational content suggested by the case studies means it is often impossible to separate the subject being taught from the teaching and learning strategies employed. However, some elements of programme content are not process-specific. There are also elements of learning about multiprofessional teamwork which could be equally well managed through monoprofessional learning; for example, learning about different types of team and their impact on the nature of teamwork, and how teams function within the context of the

organisation does not depend on a multiprofessional forum, but could be delivered as lectures or small-group teaching. In either case, it might be most appropriate to start from a consideration of the monoprofessional team, before bringing in cross-professional complexities.

For most learning needed to support multiprofessional teamwork, an appropriate teaching and learning process is as important as the specific content. Students need to:

- be aware of different professional roles and to understand the type of rationale which underpins actions/decisions
- communicate in an interprofessional arena, using assertive and facilitative communication styles across status differences
- take on team member and team leader roles, depending on the nature of the problem, rather than the status of the professionals involved
- recognise and value multiple perspectives on problems and differences in value/belief systems
- be aware of the stereotypes they hold of other professions and their limited value
- deal effectively with interprofessional conflict, learning to treat it as positive challenge and to utilise it to hone their professional skills.

The clinical case studies also showed that students need to:

- be aware of joint practices: joint report/handover, shared notes, joint planning and evaluation and their potential benefits for patient care
- recognise that the team is a social as well as a functional entity, and that all members are needed to build and maintain it
- learn to work flexibly within different team patterns and to deal effectively with change; role boundaries shift over time and in relation to specific contexts, and students need to understand their role in a given context, in relation to the 'jigsaw' of other roles, while keeping sight of their own professional core activities
- learn the skills of being a newcomer and seeking a helpful team member to facilitate their acceptance, and to develop the skills of incorporating other professionals into a team of which they are already a member.

9.1.2 The process of multiprofessional education

The majority of the learning agenda identified above can only be effectively learned through interactive strategies. This suggests the utilisation of small multiprofessional groups, enabling the sharing of experiences and expertise.

Many of the appropriate attitudes and skills are hard to construe outside the practice environment, which suggests that case-based learning might be appropriate, utilising the skills of interaction in relation to specific problems. It might also facilitate interprofessional sharing if two students from each profession were included in each group, enabling them to discuss and refine a monoprofessional argument before putting it to other members.

Although such learning might focus on patient problems, it is equally possible to conceive of exercises focusing on team problems, complex interprofessional communication and some of the joint activities already mentioned.

Scenarios would need to:

- enable the development of particular skills
- ensure that all members had the opportunity to be a team leader and a team member

- enable students to move from monoprofessional situations through collaborative multiprofessional situations before being faced with scenarios in which professional roles and opinions might be expected to conflict.

9.2 Comparison of the teamwork agenda and current patterns of multiprofessional learning in higher education

The clinical case studies suggest that considerable benefit can be gained from interactive multiprofessional education. However the survey identified little multiprofessional education being offered despite the rise in numbers of primary and community care initiatives since 1992 (Barr and Waterton, 1996). Also, little of the multiprofessional education on offer follows the pattern suggested by the NHS agenda.

Quantitative data from the survey include the distribution of current initiatives in terms of pre- and post-qualification education and categories of learning focus (e.g. biological science; research; interprofessional issues). These categories are illustrated below in 'thumbnail sketches' of initiatives drawing on questionnaire responses and interviews with staff.

Following presentation of the survey data, telephone interviews and follow-up visits identified factors constraining the provision of multiprofessional education which may go some way towards explaining the mismatch between current provision and the agenda identified in Chapter 8.

9.2.1 The national survey of initiatives in multiprofessional education

The aim of the survey of educational institutions in the UK offering pre- or post-qualification education programmes for health and social care professionals was to gain an insight into the extent, nature and purpose of multiprofessional learning and identify initiatives in which nurses, midwives and/or health visitors undertook learning with other professions. An initiative might be a whole programme, a module, or a workshop/study day. The survey separated pre- and post-qualification education using the following definitions.

> **Pre-qualification education:** education leading to entry to a particular profession (e.g. programmes for nurses wishing to register as midwives, undergraduate medical education and pre-qualification house officer training, pre-registration physiotherapy).
>
> **Post-qualification education:** education for which membership of a profession is a prerequisite, or which is designed to serve health care professionals as one among a number of professional groups.

As well as providing an overview of national provision, the survey was the first stage in the process of identifying appropriate initiatives for further study. Two questionnaires were distributed, the first seeking information about the extent of provision and the second exploring the initiatives in greater depth. Questionnaires were distributed to all higher education institutions running programmes for health and social care professions. The response identified a wide spectrum of types of initiative, which appears to be representative.

The first questionnaire included questions about the spread of health care professions taught within the institution and whether they were taught at a pre- or post-qualification level. It asked respondents to list multiprofessional learning initiatives and specify the professions involved. The second questionnaire was designed to capture information about the following aspects of each identified initiative:

- the professions involved and the number from each profession
- status: when was it implemented, or whether it was still just a proposal

- who instigated the development and for what purpose
- the topic area, the nature of the teaching and learning process and the aims and learning outcomes
- the length of the initiative and how it fitted in with the overall educational process for different professions
- the financial and resource implications
- the response of students, teachers, and professional bodies.

The first questionnaire was distributed to a named person in each of 181 faculties/departments; it was not restricted to institutions offering nurse education. The response is shown in Figure 9.1: although only 74 contacts identified multiprofessional initiatives running or under development, 206 initiatives were identified, including 13 from one institution. The majority were in post-qualification education (68%).

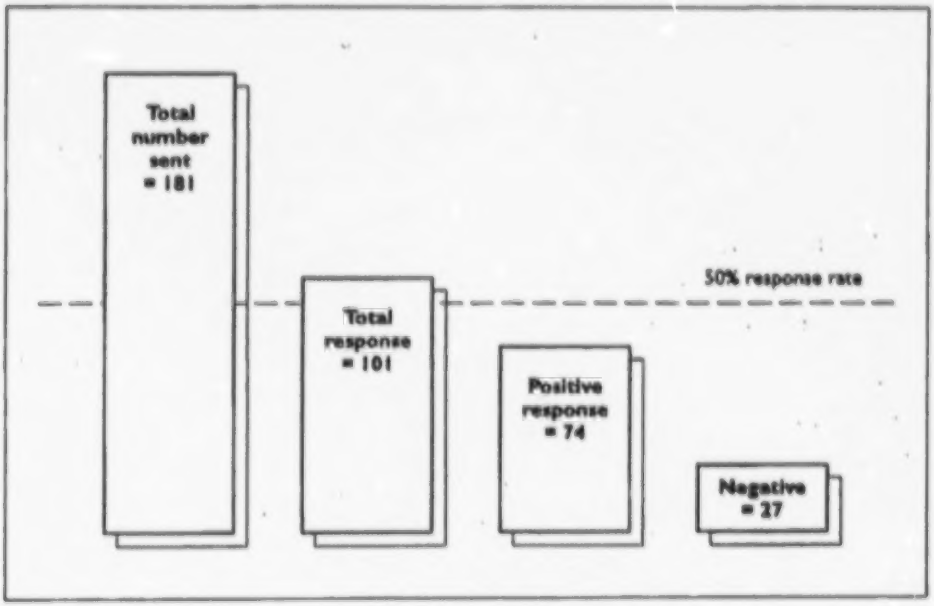

Figure 9.1: Responses to the first postal survey

A second questionnaire related to each of the 206 initiatives identified; 95 were completed and returned. In terms of pre- and post-qualification education, the profile was consistent with the first questionnaire; 65 (68%) related to post-qualification education, 27 (28%) to pre-qualification education, and three (4%) involved pre- and post-qualification students.

9.2.2 Academic level of programmes

The second questionnaire showed considerable emphasis on degree-level learning, particularly in initial education. Figure 9.2 compares results for the two categories.

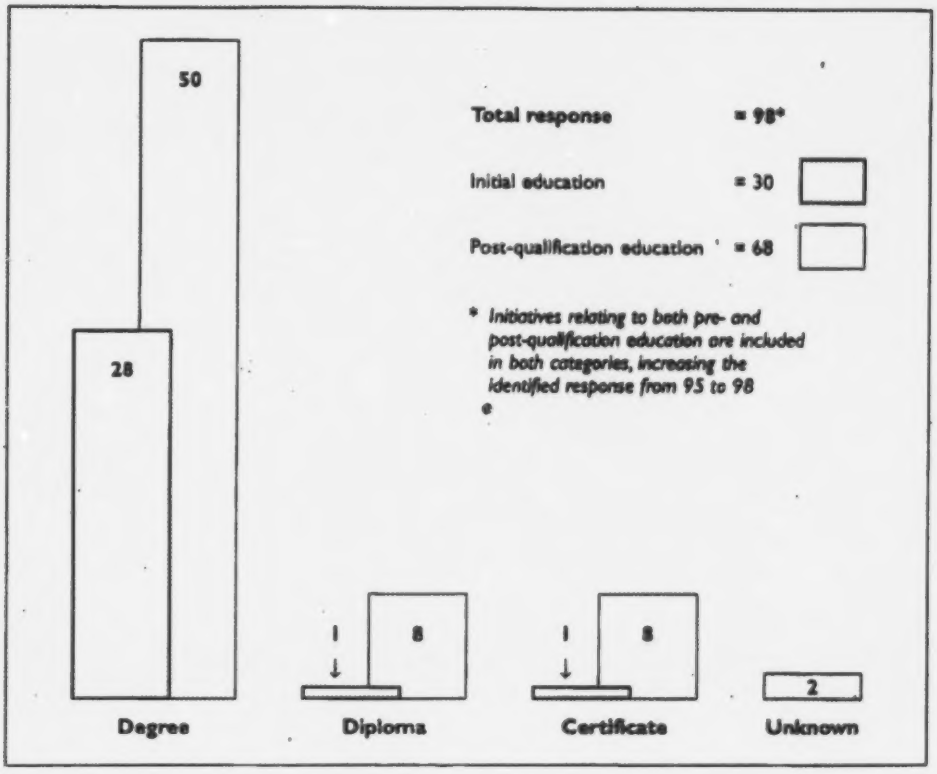

Figure 9.2: Academic level of initiatives in initial and post-qualification education

9.2.3 Breadth of professional involvement

A broad spectrum of professions is involved in multiprofessional education; most initiatives (85) included nurses; of the remainder, eight involved different PAMs and two involved PAMs and SWs. Although the questionnaire was not designed to capture initiatives which only involved nurses, midwives and/or health visitors, seven of the 85 involving nursing were of this type, leaving 78 involving nurses or nursing students with other professions. Figure 9.3 shows the balance of different combinations.

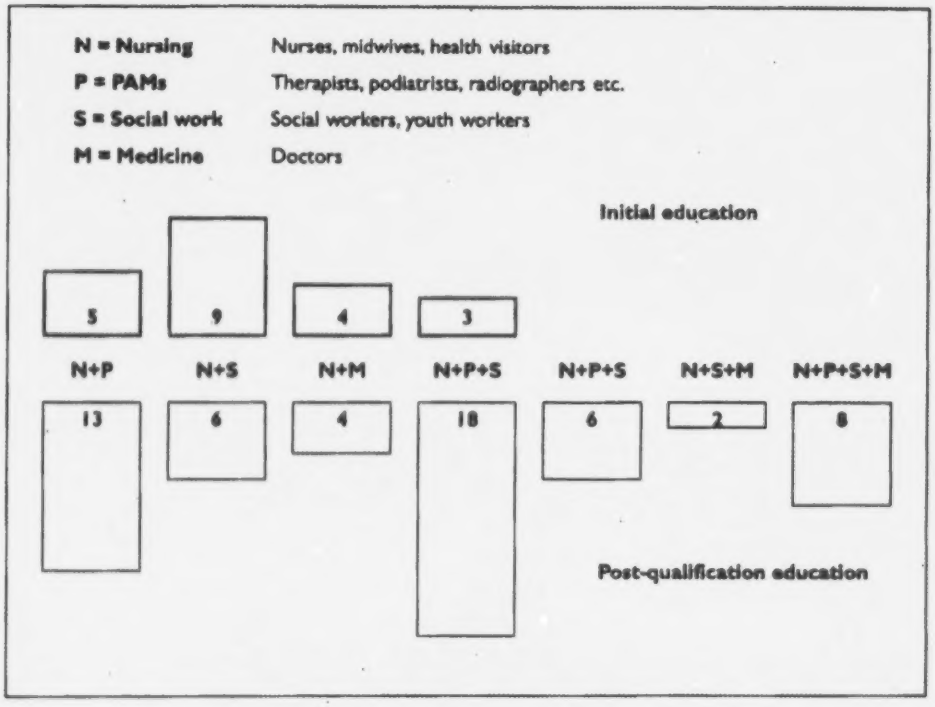

Figure 9.3: Professionals involved in shared learning

9.2.4 Who instigated the initiative?

The overwhelming majority of initiatives were instigated by higher education alone, with small numbers being instigated by health care providers/purchasers alone, or jointly with higher education institutions (Table 9.1). Three respondents did not provide this information.

	Higher education instigated	Jointly instigated	Health service instigated
Initial education	22	6	1
Post-qualification	40	17	6

Table 9.1: The instigation of initiatives

9.2.5 The nature of the initiatives

The main categories of learning focus are shown in Figure 9.4, illustrating the emphasis in initial education on common learning in biological and behavioural science, compared with a broader role-based agenda in post-qualification education. The figure shows the proportion of identified initiatives falling into each of eight broad categories. The boxes are scaled to illustrate the proportion falling into a category, rather than the absolute number; thus the 51% of initial education accounted for by 'common theory' includes four biological and five behavioural science programmes. In post-qualification education, there were two initiatives in biological science and five in behavioural science, constituting 14% of initiatives. Examples of each category of programme content are given below.

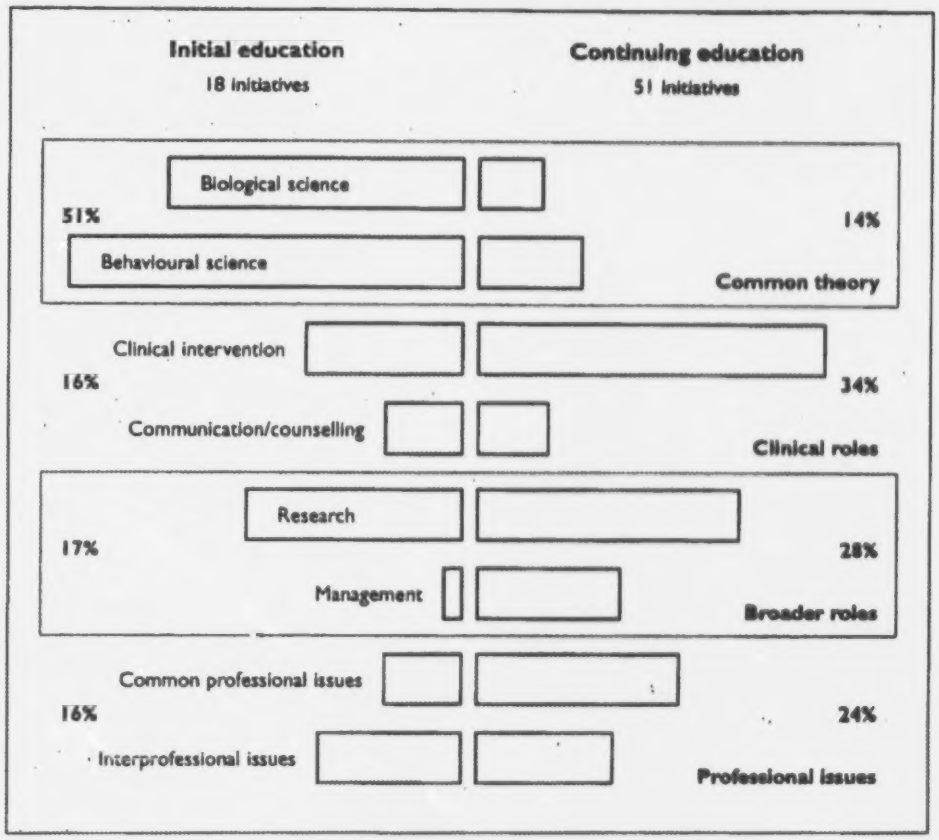

Figure 9.4: Proportion of initiatives in each category

9.2.5.1 Pre-qualification biological science: Physiology for health care professions

This Level 1 programme aimed to teach basic physiology to a range of professions including nurses, OTs, PTs and radiographers, undertaking pre-qualification education through degree programmes. Its aims recognised the need to provide knowledge which was appropriate to the individual professions, in terms of educational background and clinical role. There was a stated intention to foster effective multiprofessional teamworking skills, but teaching was largely in the form of lectures, with limited small-group work.

9.2.5.2 Pre-qualification behavioural science: Module in behavioural sciences

This module formed part of pre-qualification degree-level education for nurses, OTs, PTs, radiographers and orthoptists, undertaken during the first year. Numbers of students from the professions varied from 26 (orthoptists) to 52 (OTs). The module had been running since 1992, although the groups involved have changed in that time; it was taught by a health psychologist and a medical sociologist.

Although the module aimed to provide knowledge which there was a common requirement for each profession, the subject matter touched on different professional roles. The emphasis in teaching methods was heavily towards lectures, although some small-group teaching took place. Outcomes for all students were the same and there was a common written examination.

9.2.5.3 Post-qualification clinical intervention: Care and management of persons with AIDS/HIV

This developed from the ENB 934 programme of the same name and was offered to a broad range of professions. In addition to doctors, nurses and midwives, it had been taken by health educators, prison officers, teachers and members of voluntary organisations. However, cohorts consisted largely of nurses and midwives.

The programme required considerable self-exploration as well as exploration of the perspectives and roles of the various professions involved and the legal and ethical context in which health care takes place.

Since the care of persons with AIDS/HIV involves multiprofessional and multi-agency teamwork, developing interprofessional understanding was seen as being of paramount importance. Although students needed to demonstrate awareness of the multiprofessional context, they were assessed on their application of learning to their own area. The programme was planned, managed and taught by a range of professionals and representatives of user groups.

9.2.5.4 Post-qualification communication and counselling: Diploma in Professional Studies in Counselling

This post-qualification programme was open to nurses, midwives, HVs, OTs, PTs and SWs. Cohorts to date had consisted predominantly of nurses: in the first year there were 12 nurses and six members of other professions. This was reflected in the teaching, which was undertaken mainly by nurses and midwives.

The programme aimed to provide participants with counselling skills to apply within their own professional work rather than to enable them to become counsellors. All teaching was multiprofessional, although students were required to demonstrate application of learning to their own profession and a supervisor from that profession was sought.

The sharing of experience within the group was seen as being of fundamental importance. Students learnt as much from each other as from formal teaching. However, the promotion of multiprofessional teamwork was not an explicit intention.

9.2.5.5 Pre-qualification research: Research methods and statistics

This module formed part of the pre-qualification education for nurses, diagnostic and therapeutic radiographers and orthoptists. It took place in the first year of degree programmes and had been running since 1994. Professions were comparatively evenly represented, with 30 students from nursing, 25 from each of the radiography disciplines and 30 from orthoptics.

Although the programme introduced both qualitative and quantitative research methods, it was run by a statistician and the emphasis was heavily towards quantitative approaches. The main teaching strategy was the lecture, although the supplementary small group teaching was important. The intention of running the programme on a multiprofessional basis was primarily to reduce cost. Any potential for students to learn from each other was a bonus. Students undertook the same written examination at the end of the programme.

9.2.5.6 Post-qualification research: MSc Research (Health)

This programme had been running since 1994 and had attracted broad range of professions including, nurses, doctors, dieticians and SLTs, OTs, and PTs, although nurses predominate. Only 10 students were taken each year.

The programme was designed to meet a learning need identified as being common to all the professions concerned. Through working in a multiprofessional educational context, students were exposed to a broader range of experience and ideas.

Formal teaching was focused in the early part of the programme and was largely interactive. As the programme progressed, student-led group work and independent study came to the fore. Assessment was common to all students.

9.2.5.7 Post-qualification management/teaching: MSc in Health Care Management

This two-year, part-time programme was aimed at senior professionals. In addition to doctors, midwives, nurses and HVs, the current cohort of 14 included a general manager and a trust chairperson.

The modular programme covered aspects of management including: finance/resources; quality; law and ethics; organisational behaviour and education/development. It was designed to build on and offer education missing from less focused MBA programmes, and its multiprofessional nature was intended to promote the sharing of ideas, problems, and decision-making approaches.

9.2.5.8 Pre-qualification common professional issues: Common issues in mental health

This one-day workshop for students in mental health nursing and social work was first implemented in 1995, it was originally a one-off trial, but was planned to be repeated. The cohort was split relatively evenly between the professions, as was teaching/facilitation.

The workshop took place early in the second half of the respective programmes. It allowed students to share experiences and used patient scenario-based exercises, and aimed to recognise issues common to both groups, to share perspectives and to broaden students' outlook. This learning could not be achieved in a monoprofessional setting. The planners believed that cross-fertilisation of ideas through this programme was valuable to the professional development of both groups.

9.2.5.9 Pre-qualification/post-qualification interprofessional issues: Advanced clinical skills

This one-day programme brought together 10 final-year medical students and 10 recently-qualified nurses. Although the title reflected programme content, it was intended that the day would foster the development of communication skills and teamwork within the context of clinical learning. It first ran in Autumn 1995 and was planned jointly by medical and nursing teachers; this co-operation was carried forward into implementation, where team teaching was an important element.

Students worked on a patient scenario which provided the context in which skills would be learned. They had different skills/levels of skill and were expected to achieve different specific outcomes. Subjects covered included cannulation, prescription and administration of drugs and breaking bad news. Students worked co-operatively in small groups, sharing expertise; they reported gaining a real insight into each other's roles.

9.2.5.10 Post-qualification interprofessional issues: Healthy alliances

This one-day workshop involved staff training for primary care work, including GP registrars, trainee HVs and SWs and a wide variety of community nurses, including paediatric, psychiatric and school nurses. Its purpose was to develop improved interprofessional understanding and working patterns.

The workshop revolved around a developing scenario involving a family with multiple problems. Students began in monodisciplinary groups; they got a 'referral' relating to one family member and considered appropriate action, information needed from other disciplines and whether to should involve others in the case. They also had to answer queries from other

disciplines about other referrals. Multiprofessional groups were then formed to hold a 'case conference' on the family.

9.2.6 The mismatch of teamworking and current education

The survey highlighted major differences in the nature of interactions expected between students in multiprofessional groups; many, especially in pre-qualification education, did not require any interaction between professions, and can be typified as bringing students together because they were considered to have common learning needs, rather than learning they could share. Such 'common learning' is particularly prevalent as part of foundation studies.

By contrast, initiatives encouraging students to learn from and about each other (shared learning) tended to occur later in pre-qualification education or as part of post-qualification education.

Little multiprofessional education in universities addressed interprofessional issues. The survey, along with the telephone interviews and visits, identified a range of potential reasons for this mismatch; many related to the organisational and other practical constraints discussed later in this chapter, but the most fundamental reason was that most higher education provision was never designed to meet that agenda.

The telephone interviews made clear that initiatives which did address the teamwork agenda were invariably instigated by one or more individual professionals with a particular interest in the clinical outcome. The majority were designed to meet the legitimate organisational aims of the higher education provider.

9.2.7 The higher education agenda

'A lot of shared learning you hear about is just about the sharing of resources using a single teacher. Sometimes the economics of scale seem to be more important in the rationale for multiprofessional learning than any educational advantage. You can see the pound sign in their eyes.'
(Course director)

Higher education institutions are as enthusiastic in support of multiprofessional education as trusts are of multiprofessional teamwork. However, this enthusiasm is not focused on meeting a need for teamwork education. The university agenda is focused on the economics and flexibility of provision.

The majority of universities provide education for a number of health care professions. Professional health care programmes are affected by the manpower needs of educational consortia, and since these vary annually, the contracted number of places for each profession will also vary, resulting in a considerable incentive to provide programmes which allow the switch of professional numbers without altering staff numbers, departmental structures etc.

The economics of professional education also push universities towards a multiprofessional approach. In pre-qualification education, the data show that programme content tends to be scientific knowledge. There is a tendency to suggest that anatomy is anatomy, whoever is learning it (although the assumption of a common learning need may be ill-founded). If this is accepted, the subject can be provided in lectures to all groups simultaneously. Whatever the subject, such universal provision tends to be seen as appropriate at a foundation level. In post-qualification education, there is an equivalent 'problem', with many programmes focusing on common content and outcomes. The result is less serious, because more senior professionals can apply learning to their own context themselves.

The higher education agenda therefore promotes a pattern of multiprofessional education which assumes commonality rather than utilising and valuing differences; it values large-group, didactic teaching rather than small-group interaction and, in pre-qualification education, pushes provision to the early part of the programme.

Health service and higher education agendas push multiprofessional education in opposite directions in pre-qualification education (the former towards small-group interactive learning, the latter towards didactic lectures). If the NHS views the multiprofessional agenda as sufficiently important, consortia must be encouraged to specify it in contracts and allowed to pay the extra costs incurred by education providers.

9.3 Other barriers to multiprofessional education

Not all barriers to effective multiprofessional education are as intransigent as the mismatch between the higher education and NHS agendas. The following areas were identified by a number of respondents, but respondents also identified solutions or part solutions; those identified at the end of each section are an extrapolation from these responses.

Historical and current patterns of higher education provision for health care professions vary considerably. These differences throw barriers in the way of multiprofessional initiatives on a number of levels, including organisation, logistics of timetabling, group size, and timing and appropriateness for students. These are discussed below.

9.3.1 Organisational barriers

> *'The opportunity for the clinical skills laboratory and joint teaching arose because [institution] had both a medical school and a school of nursing ... The medical school has now gone to one university ... and we've gone to another. I don't think the same initiative would have arisen in those circumstances.'* (Course director)

Medicine has a long history in higher education, and education is largely provided by long-established universities. In contrast, the recent entry of nurse education into higher education has most commonly been through institutions only recently awarded university status.

These newer universities are also the home for other health and social care professions, which preceded nursing into higher education. Schools of nursing often joined universities with existing health and social care programmes, including some nursing provision. However, the scale of the newcomer and its perceived potential to irrevocably change the culture of pre-existing provision has often meant that such schools maintain a semi-independent status.

Some initiatives studied in this project worked across organisational boundaries. Sometimes this was an accident of history, relating to organisational links which had since been severed. Sometimes the links were purposive and set up simply to enable the initiative. Although multiprofessional education can involve students in different faculties and, on rarer occasions, different universities, respondents identify that such divisions affect the ease and sometimes the quality of co-operation. The potential reasons include:

- **incompatibility:** all faculties work within university guidelines, but their interpretation of those guidelines may differ
- **lack of leadership:** because faculties retain a high degree of autonomy, there may be no one person in a position to encourage co-operation
- **complex accounting:** changes in accounting procedures have replaced the informality of reciprocal arrangements with formal identification of cross-faculty teaching time
- **lack of knowledge:** initiatives may flounder because staff in one faculty are not familiar with staff, programme organisation or student profile in another.

Many respondents identified timetabling difficulties as a major barrier. Finding a point at which two or more groups can embark on a joint programme requires the identification of either:

- a common learning need which can be appropriately met for both groups at the same time

- a time at which each group can satisfy its educational needs through learning from each other.

Even where common needs were identified, some respondents suggested that the appropriate timing for each group might differ. Issues cited included differences in: educational background of the cohorts; the way in which the educational content slotted into the overall structure for individual programmes, or the conceptual framework for the individual profession; and the level of practice experience at any given point in the programme.

At the 'whole programme' level, especially in pre-qualification education, the overall length of the timetable could relate to requirements from professional bodies and legislation. Pre-qualification education for medicine and dentistry involves five-year programmes, whereas that for the majority of health care professions takes three years. The fact that this is the same length as a standard university degree is coincidental, since, for example, nursing programmes were the same length at certificate level. This suggests that there is a logic to the differences in terms of the learning required.

The organisation of programme components for each profession may also be constrained by nationally-determined criteria (such as the common foundation/branch split in nursing education) but are equally likely to be shaped by tradition. Whereas nursing programmes have traditionally introduced practice experience early in the first year, PAMs students may have their first practice experience at the end of the first year and medical students after two years. Although these patterns of organisation may be changing, the differences are still marked.

At the level of detailed timetabling, respondents reported difficulties in managing multiprofessional learning which were analogous to co-ordinating diaries to find an appropriate time for a meeting. Everyone can have 'signed up' to the initiative and agreed the learning agenda, but getting professional cohorts together may be difficult.

As with any problem relating to programme organisation and timetabling, the level of difficulty will be proportional to the number of programmes which an initiative aims to serve.

The majority of timetabling problems identified relate to the historical context. Most initiatives are 'bolted on' to pre-existing monoprofessional programmes, and must work round existing elements. Even where shared or common learning is implemented as part of a new programme, the institution will normally have provided education for the professions concerned through previous monoprofessional programmes, and custom and practice may slow change processes.

9.3.1.1 Possible solutions

Respondents suggested a number of ways to overcome barriers created by organisational division. The simplest might be described as the *'barrier, what barrier?'* response.

The initiative for programmes involving shared interprofessional learning almost always came from highly motivated members of health care professions, who often maintained clinical links, including cross-professional links. Finding an interested colleague in another faculty or university was relatively easy, and the growing number of cross-professional organisations helped.

Where proven common learning is required by different groups at different times there may be little potential for an effective solution unless groups may be mixed across years (e.g. second-year nurses with third-year medical students). This works in terms of shared learning, where equivalent rather than common learning is expected. One initiative saw shared learning between senior medical students and recently-qualified nurses; each group felt they had something to learn from and to teach to the other.

Other respondents suggested strategies which could ease timetabling problems and organisational divisions through the use of information technology. One suggested that a virtual

group working across universities could undertake problem-based learning through computer conferencing. Another initiative utilised the Internet to allow students to log on to a central computer, download a 'problem' and put file responses. Other students logging on would then get both the problem and their colleagues' responses and could respond to both. With this type of solution interprofessional work is timetable-free. However, there was general agreement that computer-mediated interaction would never completely replace face-to-face groupwork.

9.3.2 Cohort size: majority and minority problems

> *'Because of the student mix and the large number of nurses involved, there is a danger of nursing issues dominating. It only happens some of the time. It depends on the module ... on what subject we're teaching.'* (Course director)

As with any other university programme, the size of cohort in health and social care programmes is partially at the whim of applicants. No one can produce a cohort if there are no candidates and there is considerable risk involved when institutions reduce standards of entry to fill places.

Pre-qualification programmes for health and social care professions must contend with a further problem in relation to contractual arrangements with education purchasing consortia. These groups of NHS trusts determine their manpower requirements annually and use these figures to calculate how many higher education places they are willing to fund. The number of places which universities can offer is also affected by the professional bodies, who may determine the number of students which local care environments can support. In post-qualification education, the representation of any profession in a programme cohort may depend on different funding arrangements and the willingness of (or requirements from) managers to free staff to attend.

Faced with these factors, it is unsurprising that respondents identified considerable differences in the size of professional cohorts taking part in multiprofessional programmes; in one case, the smallest group consisted of 16 students, and the largest of 160.

Considerable efforts were made by some interviewees to 'flatten' this differential by suggesting that the large cohort (often nurses) could be divided into specialties or branches. Although their end qualification might be different, the fact that all were currently members of a common foundation programme or community pathway suggests that this division was a little contrived. There were equal efforts to group the smaller therapy cohorts, although this link often appeared to be little more than semantic.

The intended benefit of 'massaging' cohort figures was clarified by the problems identified in relation to differences in professional group size. Problems could be experienced by both majority and minority groups.

The problems for minority professional groups related largely to didactic teaching. A number of respondents identified that students saw lectures as being tailored for the majority group, and a number suggested that even where lectures were specifically aimed at a multiprofessional audience, there was a tendency for minority groups to see themselves as being less well served than the majority. Since respondents were often members of the majority profession, such a contention might benefit from further scrutiny.

The use of practice-based examples was common in lecture programmes. Sometimes these reinforced students' perceptions of bias, focusing solely on the largest audience. In other cases, genuine efforts had been made to provide a range of examples to match the professions involved, but there was a resulting tendency for each group to consider only part of each lecture relevant to them. One interviewee stressed the importance of finding issues of relevance to all the groups involved as a means of avoiding any perception of bias. This may be difficult because the mix of students is determined by programmes in the faculty. At a concrete level, there may

be no common issues for those professions present, and abstractions cannot help students to apply learning.

The position of the majority professional group was not without its problems. Difficulties related to small-group learning initiatives and especially to situations where shared learning between professions was a requirement. Some respondents reported that there were insufficient members of the smaller professional cohort to distribute round all the small groups.

Where each professional cohort is expected to contribute specific knowledge or a specific perspective, the reduced spread of professions available to a particular group was seen as impoverishing the learning opportunity. The problem of spread was exacerbated because students were typically distributed between small groups in pairs to avoid any sense of isolation or students from poorly represented professions being overwhelmed by the other group members and not putting forward their views.

9.3.2.1 Possible solutions

Didactic multiprofessional learning has inherent problems related to the varying learning needs of a mixed audience. Even if clinical relevance and exemplification were equivalent for all, it is difficult to see how multiprofessional learning could offer *added* value in such essentially non-interactive initiatives. However, a forum, in which clinicians from each profession would offer perspectives on a case and discuss their rationale for action would develop shared knowledge of professional roles and a model of interaction.

If the professional spread within the whole cohort is based on manpower requirements, it is likely to reflect the real situation in the clinical area. There may be only one OT attached to a ward with 10 or more nurses; however, that OT will also be a member of a monoprofessional team covering a wider area, with whom she can discuss issues, share ideas and seek corroboration.

This monoprofessional back-up is mirrored in a number of small-group teaching initiatives, where students from a single profession will discuss a problem and agree a response before offering it in a multiprofessional forum. One problem-based initiative took this further: after the monoprofessional groups had met to discuss the problem and multiprofessional groups had been formed, members of smaller professions were asked to act as 'consultants' to a number of groups, rather than members of one. Varying roles in this way would appear to offer a solution.

9.3.3 Timing and professional socialisation

> *'When the students come into the lecture theatre they sit in blocks of the same profession. You feel like asking them to move around and mix up but ... They are very partisan when they come in, but that's all part of their socialisation. They have come to train to be physios, nurses etc. and they're not interested in the multiprofessional side.'* (Course director)

The previously identified difficulties regarding the timing of common or shared learning related to compatibility between professional programmes (and cohorts). Where these difficulties have been overcome and an appropriate slot identified, a further timing issue arises. This relates to the effect of multiprofessional learning on an individual programme and specifically on the process of professional socialisation.

A number of respondents felt that multiprofessional learning at an early point in pre-qualification education would interfere with professional socialisation, resulting in students and qualifiers with a less clear sense of their own identity. The perception was that students had a natural monoprofessional focus during their early education, which they maintained until they had sufficient confidence to move into the multiprofessional arena.

The survey demonstrated that the predominant type of multiprofessional initiative during early pre-qualification education is didactic common learning. Therefore, although the

concerns of respondents were not explicitly dependent on the nature of the learning proposed, it is appropriate to consider this type of initiative as the context for the comments made.

Respondents who expressed the strongest concern about early multiprofessional learning were often from the smaller professional groups whose students felt disadvantaged in terms of content, focus and exemplification. Respondents from the majority groups also expressed reservations, especially where common learning was delivered by professionals with no background in health care. In both cases, the fundamental difficulty relates to the application of theory to practice. During early pre-qualification education, students lack practice experience, and such application processes are difficult for them to achieve for themselves.

Although socialisation may be affected by this lack of facilitated application of general theory to the practice of a specific profession, another common factor must be considered. Exposure to members of one's own profession is a key factor in the socialisation process, and is lacking in both situations identified above. If theory were provided wholly by teachers who were not from a student's profession, and professional contact was restricted to clinical practice, patterns of socialisation might be threatened. However, such initiatives almost always constitute a minor component of the overall programme and it seems likely that multiprofessional learning is made less effective by students' natural monoprofessional focus, rather than multiprofessional learning in some way threatening monoprofessional development.

A further factor in the responses about socialisation in multiprofessional education is worthy of mention. The tendency for concern to be expressed by small professions about their larger 'neighbours' appeared to be exacerbated where a profession was fighting to establish or protect its independence. Other types of boundary dispute, for example where a profession was felt to be involved in *'territorial incursion'* or *'role dumping'* appeared not to raise the same concerns.

A small number of respondents took a more positive view of multiprofessional education, suggesting that current patterns of monoprofessional socialisation carried negative stereotypes of other professions which could bedevil teamwork. It was felt that multiprofessional education at an early stage offered an opportunity to ameliorate these prejudices. In this context, two problems needed to be considered.

First, it was impossible for multiprofessional education to begin before monoprofessional socialisation was under way, since socialisation started long before students entered professional education, beginning (however inaccurately) with the media and continuing through career selection and application. By the time students entered the programme they had an image of their chosen profession, and of other professions in the field and the relationship between them. Clearly, this does not mean that early exposure to students from other professions might not modify their views, but it does mean that the monoprofessional focus (which was felt to blinker them to early multiprofessional learning) was already in place.

The second problem identified by respondents related to the process by which effective exposure to students from other professions might be managed. If multiprofessional learning was to enrich a programme, students must be in a position to take a profession-specific perspective. Although the process of professional socialisation might be underway when students enter a programme, it was unlikely to have advanced to the point where they felt confident that they were taking an appropriate professional stance. In addition, case-based work of any kind, required students to share professional knowledge and practice experience. In early pre-qualification education, both were recognised as being in short supply.

The identified problems might suggest that, even if those advocating early multiprofessional socialisation were correct, practicalities would continue to favour the placing of multiprofessional education late in both pre- and post-qualification education.

9.3.3.1 Possible solutions

This is an intractable problem. Socialisation into an individual profession is a vital component of education, and the timing of multiprofessional initiatives must utilise the flow of this natural development process, rather than trying to counter it. The major concerns (about the disruption of the socialisation process or the effect of socialisation on possible learning) relate to the early part of the programme.

The view of early multiprofessional learning may be inextricably bound up with perceptions of what type of learning is possible. There appears to be a danger that negative perceptions of these early processes may colour the views of teachers and students about any multiprofessional learning. If this is the case and the effectiveness of shared case-based learning later in the education process is being damaged, one solution may be to avoid multiprofessional education until a point in a programme where such effective processes are possible. However, another solution is suggested in Chapter 10.

9.3.4 The balance sheet: profit and loss

Numerous respondents appeared genuinely to welcome multiprofessional education and what it might achieve, but to mourn what was being lost in relation to monoprofessional provision. Multiprofessional education was seen as offering invaluable opportunities for students from different professions to interact, learn about each other's roles and develop into effective team players. However, the more focused nature of monoprofessional teaching, combined with the relevance of *all* clinical examples and the taught application to the single professional role, was seen as too important to lose. The question expressed was whether the profit of the former was worth the loss of the latter.

A number of respondents felt that the loss outweighed the profit. Many who were antagonistic towards multiprofessional learning insisted that, if it could be incorporated without the loss of focused monoprofessional learning, they would be happy; however, since the curriculum was not elastic, they would continue to resist its inclusion.

Respondents considered two aspects to the equation of profit and loss. The first related to a change in process: the majority of multiprofessional programmes covered content which would previously have been delivered on a monoprofessional basis. Since making the programme multiprofessional did not increase its length, the only possible loss over previous provision was in the quality of coverage; a number of respondents felt that this was the case, citing the loss of focus and difficulty in identifying appropriate examples.

Although institutions identified a profit in relation to economy of provision, the majority of respondents perceived no educational benefit. For those who perceived a loss of focus or application, the equation was therefore simple. Many who saw the equation for this type of initiative as positive agreed that the economy of provision (and therefore the security of jobs) outweighed concerns about loss of quality. Others came from a scientific discipline, rather than a health profession, and were often dismissive of differences in professional learning needs.

The second profit and loss equation relates to multiprofessional initiatives which introduce new areas of learning, displacing previous curriculum content. In pre-qualification education, such new initiatives would commonly include learning aimed specifically at multiprofessional communication and teamwork, i.e. areas which appear to best meet the identified clinical agenda. Although many respondents saw the potential profit of this pattern of multiprofessional learning as considerable, they reported that others still felt that it was outweighed by the loss of the displaced content.

9.3.4.1 Possible solutions

Unless a way can be found to demonstrate real educational benefit achieved through didactic teaching of 'common' learning, the equation for this type of initiative is bound to remain negative for many teachers.

To some extent, the profit and loss equation as it relates to shared learning is falsely expressed or perceived, since learning about interprofessional teamwork and communication is largely mediated by the nature of the teaching process, rather than specific content. During the later stages of pre- and in post-qualification education, much of the focus of learning is on clinical problems; this learning could be enhanced if it is managed, in part, through interprofessional case-/problem-based learning.

While the appropriate cases/problems for teaching and learning in a multiprofessional forum may be limited by the range of students involved, there is no reason why a strand of multiprofessional problem-solving should be seen as taking students away from more relevant cases. If such a strand were a component of a larger, case-based programme, students would be able to gain confidence in problem solving in the monoprofessional setting, before taking part in multiprofessional exercises. This would follow the previously identified pattern of socialisation.

9.3.5 Buying in: tailored and off-the-peg learning

> *'The communication course started as part of the nursing course. When the physiotherapy course started, they looked to see what was already extant in other courses, rather than taking on new staff themselves.'*
> (Course director)

A number of the initiatives identified were the result of a move from one profession to take on subject matter which was already part of a programme for other professions. This might have been a part of a programme or, in post-qualification education, a whole programme. Many of the problems encountered were previously identified as relating to any common learning programme, but exacerbated by the fact that such programmes were often taken *'off-the-peg'* by the new professional cohort, with no tailoring to their specific needs or involvement of their professional teachers.

A number of respondents pointed out that tailoring was not simply about content, but also about the approach to a given subject. Some professions were seen as approaching a particular subject from a scientific perspective, while others approached the same subject from the direction of general concepts.

Even when some tailoring had taken place, or the programme had been redesigned for a multiprofessional audience, respondents suggested that there could be considerable problems related to it being seen as belonging to and provided by another professional group, which could result in a devaluing of the programme. One respondent reported that the effect on students of having no professional role models involved in teaching one programme was exacerbated by members of their own professional faculty devaluing the subject matter and the move by their professional body to include it. Although this particular case cannot be generalised, the overall impression of multiprofessional learning as something rather *avant garde* and peripheral to the professional agenda has considerable implications.

In terms of the more interactive patterns of shared learning, an equivalent set of problems can occur. A number of respondents pointed out the importance of careful selection of scenarios, so that the professions involved had something to offer and, where possible, the opportunity to lead the multiprofessional group. One respondent talked of the difficulties which had occurred when a new profession joined the programme and the existing scenarios did not offer appropriate problem-solving roles.

9.3.5.1 Possible solutions

Respondents identified that the problem associated with 'taking someone else's programme' can be ameliorated, but not negated, by involving members of the new profession in programme delivery and planning. However, such a move may not overcome problems related to the new group's need for a different approach.

Where the programme relates to shared as opposed to common learning, the process is partly defined by the nature of the professional mix; with appropriate facilitation, it will adapt to the new situation. One respondent identified the importance of adapting the cases/problems to allow new students appropriate roles.

9.3.6 Visibility: front door and back door learning

> *'There is no way that the medical students would agree to spend some time just on learning about teamwork. It had to happen as part of something else.'* (Course director)

As was suggested in Section 9.2, multiprofessional learning is felt to be particularly effective when focused on skills such as interprofessional communication and teamworking. Such shared learning can most readily meet the clinical agenda of multiprofessional teamwork, through simulating and facilitating reflection on the practice situation.

However, respondents suggested that this aspect of the curriculum in pre-qualification education is not popular with students, whether provided monoprofessionally or multiprofessionally. While students do not necessarily underestimate the importance of such skills, there is a perception that they are common sense, develop naturally and do not require specific teaching and learning – a perception shared by a number of teachers; however, the clinical case studies suggest otherwise.

Although the majority of professional bodies require such skills of new members, they are under-represented in most pre-qualification programmes. This reflects the position of communication and teamworking skills as a relatively new component of many curricula, which may take time to displace more traditional content. As identified previously, new educational outcomes required by professional bodies may not immediately carry the support of the professional faculty. Since the same may be said of multiprofessional education in general, multiprofessional learning on teamwork may face double resistance.

Professional teachers who do value teamwork/communication as a focus of formal learning and shared learning as a process are unlikely to offer initiatives in this area. While enthusiasts for multiprofessional education are drawn towards this area of provision, they must take account of student reluctance when they frame the learning.

The strategy of respondents varied. Some met student reluctance 'head on' and provided learning experiences specifically focused on communication and teamwork; these often focused on the use of clinical scenarios as a means of placing the skills in a more concrete context. Another respondent took a very different approach: an agenda of teaching and learning about multiprofessional teamwork/communication was hidden behind a facade of equally valuable, but apparently more attractive learning about advanced clinical skills. The danger of this strategy was that the clinical skills became the focus, tending to subvert rather than camouflage the communication/teamwork agenda. A number of issues relevant to interprofessional interaction were uncovered during the session, but were not addressed. The respondent reported that, in evaluation, students were still negative about the communication/teamwork elements of the session, although they appeared to develop skills and comfort in this area.

9.3.6.1 Possible solutions

By attempting to hide the communication/teamwork agenda, teachers are likely to reinforce the student view that it is simply not 'headline material', and is better acquired as a natural by-product of learning about 'important' topics. If it is intended that students recognise the worth of such learning, there would appear to be advantages in making the agenda explicit from the beginning.

Respondents were positive about strategies using scenarios which demonstrated the value of multiprofessional perspectives and teamwork. As with the 'hidden agenda' model, the

development of skills of interaction accompanied more concrete learning. While the hidden agenda model uses clinical skills learning to develop multiprofessional team skills, the problem-based strategy requires the use of communication/teamwork skills to achieve problem solution. In the former, communication and teamwork remain an optional extra, in the latter their centrality to clinical activity is demonstrated. Students from different professions are not expected to demonstrate or acquire the same knowledge, but are required to bring their own perspective and expertise to bear. Co-operation therefore becomes paramount.

9.3.7 The effect of the higher education agenda and organisational barriers on the educational process

The research identified a spectrum of educational strategies (Figure 9.5) with the sort of interactive multiprofessional groupwork process suggested by the case studies at one end and a pure diet of didactic lectures at the other: from strategies which demand purposive interaction between students to strategies where interaction between students is incidental.

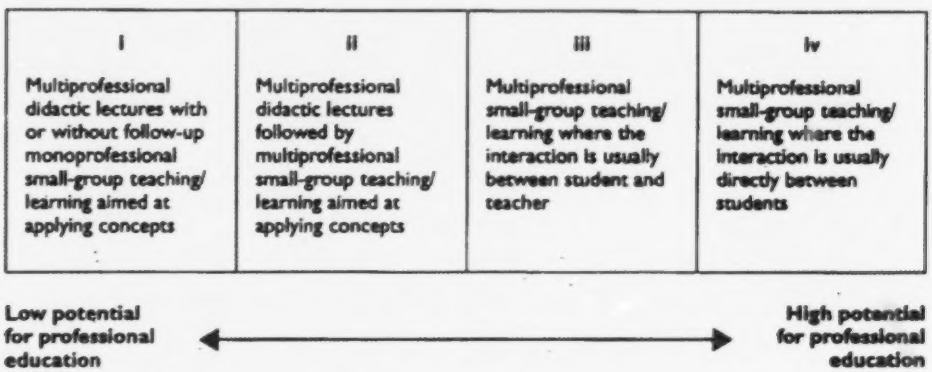
i
Multiprofessional didactic lectures with or without follow-up monoprofessional small-group teaching/ learning aimed at applying concepts
ii
Multiprofessional didactic lectures followed by multiprofessional small-group teaching/ learning aimed at applying concepts
iii
Multiprofessional small-group teaching/ learning where the interaction is usually between student and teacher
iv
Multiprofessional small-group teaching/ learning where the interaction is usually directly between students
Low potential for professional education
High potential for professional education

Figure 9.5: Potential of educational processes to facilitate interaction between students of different professions

If didactic lectures are followed by monoprofessional small-group teaching, there is no additional interprofessional learning and no opportunity for students to learn from each other. Some potential for interaction is added if didactic lectures are followed by multiprofessional small-group teaching but, having been given the basic concepts in the lecture, students will already be considering their application in the context of their own role and may fail to focus on its application to other professions. A further step towards interprofessional shared learning is the multiprofessional small-group session in which interaction takes place between students and the facilitator. Although this has many benefits of the fully interactive small group, the process does not mirror interaction within a team and process-mediated learning about interprofessional communication and teamworking will be limited.

The survey made clear that the majority of the multiprofessional learning initiatives were not aimed at meeting the teamworking agenda in terms of content or process. The potential economies of scale promised by multiprofessional education can only be realised through the sort of didactic teaching which minimises students' interaction. In post-qualification education, the cohorts tend to be smaller and educational processes are naturally more interactive, but the driving force behind the opening of programmes to a multiprofessional audience is the need to maintain or increase numbers to ensure economic viability, rather than to encourage the sharing of experience.

Where programmes did aim to utilise a more interactive, multiprofessional approach, practical difficulties often hobbled the original ambition. Many initiatives captured in the survey:

- were relatively new: with the same potential for teething problems as any innovative programme
- were built on to existing programmes: with the inherent problems of trying not to disrupt other parts of the programme
- faced resistance from some members of staff either because they felt their part of the programme had been disrupted or because of a more general mistrust of multiprofessional approaches
- had to work within existing levels of human, physical and financial resource (or were expected to demonstrate a saving)
- were brought in rapidly, under pressure from the academic organisation, with limited time for consultation and the development of ownership.

Such factors, in addition to the barriers identified earlier, tended to exacerbate each other. The result was clear when data from the survey and follow up interviews were compared. In a significant number of cases, the curriculum as planned promised something not delivered by the curriculum as implemented. The general effect was of a movement from a more to a less interactive process. Thus, facilitated interaction between students from different professions might be replaced by tutor-student interaction: the multiprofessional small-group work planned to follow a lecture might be replaced by monoprofessional working; in one case lectures to be delivered to a multiprofessional group were replaced by the same lectures being delivered to each professional group separately.

For many interviewees, this process of monoprofessional shift appeared to be a response to the difficulty in overcoming organisational inertia or particular structural problems. Others took a more proactive role and saw themselves as protecting their students and profession by taming the organisation's wilder fantasies.

The difficulties identified in this chapter in relation to structure, content and process and the response of staff to (or responsibility for) those difficulties are not specifically related to multiprofessional education. Indeed, they may be a feature of any curriculum development. The pre-qualification problems may therefore be overcome as programmes mature. As specific initiatives bed down and multiprofessional learning gains wider acceptance, what criteria may help us judge whether any new initiative is likely to be beneficial, neutral or negative? Some pointers are discussed in Chapter 10.

9.4 The professional bodies

Some of the NHS trust managers, whose views were discussed in Chapter 3, raised concerns that professional bodies would support the rhetoric of shared learning but resist it in practice, *'pulling up the drawbridge'* of protectionism, and that this would lead to conflict about interpretations of roles. No examples of this were cited, nor were managers' concerns endorsed by the survey: the majority of respondents made no comment about the profession bodies, and certainly did not identify them as putting up barriers to shared learning; the remainder said that the professional bodies had raised no objection, or were enthusiastic.

Interviews with a sample of professional bodies and the documentation provided by others, supported this; initiatives were mostly welcomed, for example:

> *'The [professional body] is not comfortable any longer with universities which do not have any multiprofessional element in their programmes. That's the advice we give to the education purchasing consortia, and the Joint Validating Committee gives to universities ... [university] suffered because they were unable to offer any shared learning in their programme.'* (Education and Practice Officer, professional body)

Another representative from a professional body had a caveat:

'We encourage multidisciplinary working ... we encourage [our professionals] to be part of the team, but I haven't seen any evidence to suggest that multiprofessional education makes for better multiprofessional working. We look towards making sure that, where it occurs, it doesn't do any harm. I've seen no evidence that it can do any good.'

Professional body representatives also agreed with the views of some programme leaders about the economic drivers for shared learning and its interpretation:

'I can't think of any post-registration professional development programmes which have come through recently which function on a monoprofessional basis. People are thinking along the lines of income generation and that pushes them towards a multiprofessional cohort.' (Professional Body's Education and Practice Officer)

This officer went on to comment on the interpretation of shared learning:

'In the universities ... I am sure the culture is there for people to own shared learning which is designed to benefit the workplace. [Region] have been problematic, because there is a lack of understanding of what shared learning really means. They see it as revolving around generic issues ... common learning ... although this is changing ... There is no discrimination in the [professional body] advice about the types of shared learning which a university may offer. But there is much more support for the <u>real</u> shared learning of case work, problem based learning etc.'

The intentions stated in formal documents and by representatives may not be experienced in the validation processes carried out at grass roots level. However, if there were any difficulties in gaining acceptance of shared learning on the part of the representatives of professional bodies, they were not flagged up by programme leaders in the way that other problems were.

One representative of a PAM raised a point about the variation in alliances between different professions at various levels which had implications for education:

'There has been a huge effort to improve the links between ourselves, Physiotherapy and Speech and Language Therapy. They are our closest political links ... links at my level. But [our professionals] on the ground would say that nurses, doctors, clinical psychologists and social workers were closer working colleagues. There is a huge impetus to improve links with these professions.' (Professional body representative)

Purchasing consortia alliances depended upon what was available in their location; if there was no medical school nor radiography training, for example, the mix in shared learning programmes purchased from higher education would not reflect grass roots professional mix. With some exceptions, doctors and dentists are educated in the old universities and nurses and PAMs in the new, adding to the planning and logistic feat of their learning together, as some programme leaders had found. These problems could be overcome through inter-university alliances, but this adds to the tariff in developing shared learning between professions which work together in practice. Chapter 10 draws together the evidence from higher education and from the case studies to suggest a model of shared learning which could bring the two closer together.

Key points

- This chapter brings together the findings from the clinical and education settings in order to develop a possible model for pre-qualification shared learning programmes.
- Broad criteria are given for the content and process of multiprofessional education.
- A model for initial education is suggested to meet the needs of the clinical novice and the probationer and to engage students in the teamwork agenda.
- The model has six key elements:
  - develops the prerequisites for teamwork
  - patient-focused
  - interactive
  - case-/scenario-based
  - built on a model of student development
  - ongoing throughout education experience.
- From the clinical case studies, four main areas are addressed as a basis for students' understanding of teamwork:
  - communication issues
  - role understanding
  - team awareness
  - strategies for teamwork.
- The introduction of these areas to students was phased to mesh with different stages of their clinical experience.
- In continuing education, recruitment and imbalances in numbers of professionals were difficulties. Opportunities for interprofessional development could be neglected once students were brought together.
- Whole team training is generally undertaken in some trusts and in regional authority programmes rather than in higher education.
- Teaching skills required for multiprofessional case-/scenario-based learning require training.
- Recent research concluded that teachers need preparation in greater depth to facilitate the more complex interactive models of learning. Much of their experience is of large classes in the 'common learning' environments which characterise higher education provision.
- A next step would be to move from developing reflection in monoprofessional to multiprofessional groups.
- In the practice environment, the challenges of training preceptors in multiprofessional supervision and competing demands on their time pose considerable challenges.
- A few institutions are establishing specific clinical environments for multiprofessional education.

CHAPTER 10

10.1 Introduction

'A model of education should start with the needs of the community – universities have started the other way up, looking at the professions, what we think of, "what can we teach across that lot" – psychology, study skills, communication, more than that is very threatening.'
(Dean of health faculty providing multiprofessional courses)

This chapter considers how the analysis of the data on team functioning and the implications of the teamwork agenda for multiprofessional learning might be reflected in higher education provision: how the barriers to shared learning identified in Chapter 9 could be overcome.

The data show that the higher education agenda is driven by an approach to multiprofessional learning which looks for economy and flexibility. These findings are supported by those of Mhaolrúnaigh et al. (1996) on teacher preparation, who concluded that educational institutions had not adopted shared learning from an educationally-led perspective. Rather the driving force in some centres was resources. However, while this may be necessary, the selection of content and teaching method determined by the drive towards educational economy and flexibility appears to offer little of value in preparing students.

A recognition of the value added by shared learning focusing on teamworking does not necessarily devalue multiprofessional education which aims to meet an identified common learning need; both may have their place. This chapter therefore looks at the general design criteria for multiprofessional education, then identifies a number of criteria for shared learning to be met in order to provide an effective foundation for the development of professionals who are confident in their own role and aware of the way in which they and their colleagues contribute to the process of teamworking.

10.2 Design criteria for multiprofessional education

Although Chapter 9 focused on the teamwork agenda and recognised its poor representation in current provision, any criteria for multiprofessional education must apply to a broader range of possible teaching and learning events. Whatever the initiative, the design criteria must relate to both content and process.

10.2.1 Content

In Chapter 9, considerable difficulties were recognised in simply bringing together a multiprofessional cohort of students. This complexity suggests that a first criterion for multiprofessional education might be that it should offer demonstrable benefit over its monoprofessional alternative. However, this fails to take account of the economic imperative in higher education, which results in a 'convenience sample' of professions (who study alongside each other in a single educational institution) being brought together for 'common' learning. A more appropriate first criterion for multiprofessional education is that it should, at least, not represent a diminution in the quality of provision for individual professions.

As identified in Chapter 9, the identification of common learning is often flawed. A major assumption underpinning many multiprofessional developments in pre-qualification education is that because a discipline (anatomy; physiology; sociology) is part of the common intellectual currency of a number of professions, it necessarily constitutes appropriate common learning. This may be the case, but it may hide the fact that each profession needs to draw differently from the discipline in breadth and depth of knowledge and that different examples will make the knowledge 'real' for different professions. In anatomy, this may relate to whole systems (physiotherapists need more detailed knowledge of the musculoskeletal system than doctors or nurses; doctors need the most detailed knowledge of the gastro-intestinal system) or

detailed selection of concepts (the piezo-electric effect in bone is of particular importance to nurses' understanding of the value of passive limb exercise in long-term bed rest).

However, there are clearly areas in which the role of individual professions overlaps. Where roles are common, it may be assumed that the knowledge required to support the role is also common. As professional bodies recognise extended roles (which, history suggests, often become incorporated into a professional core) and health care providers seek to implement multiskilling initiatives, such common learning may become increasingly relevant.

The different educational background and mental set of cohorts of students may also have to be taken into account. Even where the end-point of learning is the same, the commonality of the starting point must be considered. Students from different professions may have to meet entry criteria which vary enormously in academic qualifications or specification of subjects. Equally, where students from two professions might be said to require a common knowledge of certain concepts, their leaning towards science or the humanities may require the concepts to be presented differently.

> *'The groups of students are entirely different. The radiographers are hooked on technology, the nurses and occupational therapists on the other hand are far more interested in people. The knowledge base they need is similar but the examples and the ways you have to use to get it over to them is different.'* (Course leader)

As suggested in previous chapters, there is an alternative to the fraught process of identifying real common learning. Institutions may provide multiprofessional initiatives in which the intention is equivalent or mutual learning: students from a number of professions should have equivalent opportunity to meet their own, differing learning need through interaction with students from other professions. This is the basis of selection of cases for the team-focused learning discussed later in this chapter.

Although the selection of appropriate content is vital if the multiprofessional nature of education is to add, or at least not to subtract value, it is clear that the selection of process is equally important.

10.2.2 Process

The educational process must be tailored to the students involved, taking account of their educational background, professional experience and development, and mental set. It must also take account of the subject matter and intended outcome. Figure 10.1 shows a matrix relating factual knowledge and professional wisdom to didactic and exploratory teaching/learning. Eraut (1994) differentiates between the factual or 'propositional knowledge' required by members of a profession, which can be readily codified and passed on as relatively stable and incontrovertible facts. Professional wisdom relates to what Schön (1991) describes as the *'marshy ground'* where there may be no single right answer and where individual practitioners must utilise professional judgement. Eraut argues that the knowledge underpinning such judgements is often tacit: the way in which the judgement is arrived at may be unclear to the professional.

This division between the two types of knowledge is clearly simplistic. Factual knowledge may be open to dispute, while professional wisdom might not be capable of expression as a series of propositions, but some aspects of the thinking underpinning judgements are capable of clear expression. However, the identification of these two ends of the knowledge spectrum enable the appropriateness of different methodologies to be considered.

	Factual knowledge	Professional wisdom
Didactic teaching	**Cell 1** Lectures or other didactic teaching aimed at presenting students with a series of 'incontrovertible' facts required for their professional function	**Cell 3** The 'expert lecture', through which a senior professional seeks to make explicit their experiential learning and the basis of their professional judgement
Exploratory learning	**Cell 2** Interactive strategies giving students the opportunity to discover 'incontrovertible' facts for themselves	**Cell 4** Case-/problem-based work giving students an opportunity to mimic experiential learning and practise professional judgement

Figure 10.1: The relation of factual knowledge and professional wisdom to didactic and exploratory teaching/learning

Where a real common learning need is established, the delivery of purely factual knowledge to a multiprofessional audience may be effectively and economically managed through a didactic teaching approach (Cell 1). Such teaching does not enable or encourage interaction between different professional groups, but when the learning is a common need for all, interaction offers no advantages. However, if the aims of learning include the development of interprofessional understanding as well as the attainment of knowledge, the large-scale lecture would be inappropriate.

Learning the same factual knowledge through active small group processes (Cell 2) is a well-tried alternative. A number of additional benefits will naturally accrue from the active learning process (development of independent learning, general communication and groupworking skills etc.) but are unlikely to be further enhanced if the small group consists of a number of professions. In anatomy for example, facts are facts and opinions and perspectives are irrelevant (or at least not differentiated by profession).

The process has less potential for failing to meet the needs of different professional groups, since it would allow for common learning need to be met, while providing opportunities for different professional groups to vary their individual exploration in relation to their needs. In some circumstances there may be real benefit from a multiprofessional exploration of such factual material. The recognition of where knowledge is common and where it is different provides an important key to effective interprofessional communication.

The occasions on which professional wisdom may be transmitted through didactic teaching (Cell 3) may be limited, but there is still a place for the 'master lecture', in which experts share their experience and discuss their rationale for professional judgement. Often such lectures are designed as much to inspire students, encourage their own professional explorations and provide insights into expert practice, as to provide something specific to slot into their own practice. As such, the lecture may work effectively on a multiprofessional basis and an alternative professional perspective on a problem may provide a valuable key to its solution.

The current research has suggested that the greatest added value of multiprofessional education will be in the facilitation of learning about topics where perspectives, opinions and interventions may vary between professions (Cell 4). Such learning is likely to be focused on increasingly realistic clinical scenarios, mirroring the practice reality in which professional judgement and professional wisdom become important and the dualism of right and wrong is left behind. This is part of the expected development of students (Perry, 1968).

Where the aim is to improve multiprofessional understanding and develop the skills of teamworking, multiprofessional small groups can offer the most effective approach. Any such initiative must still take account of the professional mix of students involved. There is no

advantage to utilising a realistic scenario if, to one or more of the professions, that reality has no apparent bearing on their clinical field. Having identified a scenario from a relevant field, it is necessary to ensure that it provides students of each profession with roles which will enable the desired learning. Usually, this will mean that all professions need an active part to play, although one student interviewed recounted the valuable lesson she had learned from a scenario in which her role was to recognise that she had nothing to offer.

These broad criteria underpin the development of a number of suggestions as to how both pre- and post-qualification education could be used to prepare for or enhance multiprofessional teamworking. We begin by looking at a model for initial education which meets the needs of the clinical novice and the probationer, as identified in Chapter 8. It also takes account of the difficulty with engaging students in the teamworking agenda (and possible solutions) identified in Chapter 9.

10.3 Shared learning: pre-qualification education

Section 10.2 proposed broad criteria against which the feasibility or advisability of any multiprofessional initiative might be judged, identifying how different teaching and learning strategies might be appropriate to the delivery of different content and could enable the achievement of intended learning outcomes. While recognising that every type of initiative may have its place, this research has suggested that the value added to the learning experience is maximised by multiprofessional initiatives which focus on shared rather than common learning and which exhibit the following elements:

- develops the prerequisites for teamwork
- patient/client-focused
- interactive
- case-/scenario-based
- built on a model of student development
- ongoing throughout the education experience.

10.3.1 Develops the prerequisites for teamwork

Teamwork is vital to the delivery of health and social care. This is equally true of monoprofessional and multiprofessional teamworking. There is clearly a difference between talking about teamwork and building teamworking skills. There seems little point in lecturing students about what makes good teamwork, certainly in the early stages of their education.

Activities which progressively foster teamworking skills are likely to have most success. The clinical case studies show the main elements in effective teamwork to be:

- enabling team entry
- communication
- understanding of roles
- team awareness
- strategies for collaborative action.

The learning programme should therefore provide experiences which build up these elements. With appropriate strategies, multiprofessional education has an unmatched potential to develop teamworking abilities.

10.3.2 Patient/client-focused

Students in every health care profession are rightly centred on developing competence to provide effective treatment and/or care, and devalue any programme content which cannot

demonstrate relevance within this frame of reference. One of the difficulties in getting students to consider teamworking issues is in demonstrating their relevance. If multiprofessional education is patient/client-focused, its relevance is immediately demonstrated.

One point made to the researchers and discussed in the literature (e.g. Tope, 1998), is that if the patient and all his or her needs is the focus of the whole team, rather than predetermined aspects of patient need being the concern of individual professions, it becomes easier to see how professions can act together to meet those needs, rather than how the needs should be compartmentalised to fit professional roles. To start students with this orientation will help them later when working at role boundaries.

The status of the patient in relation to the health and social care team is changing. For example, paternalism from the medical profession is being replaced by more even relationships. This relates partly to increasing access to information: e.g. via the Internet (Bader and Braude, 1998) and partly to changes in health and health care expectation (Greenhow et al., 1998). As the patient becomes not only its focus of action, but an active member of the team, the benefit of patient-focused education for teamworking becomes clear.

There has also been an increasing awareness of the role of the carer in the patient/client's well-being and of the need to involve carers in decision-making, as well as the recognition that the carer's view of needs is not always the same as the patient's, or of health and social care professionals. The carer's views need to be appreciated as relevant to the team and therefore part of the education process.

10.3.3 Interactive

Didactic teaching aimed at enabling common learning gives no opportunity for students to find out how others have assimilated the same information, unless there are opportunities for discussion. In the same way that practitioners need to interact with other members of the clinical team, rather than work alongside them, students need to engage with other groups to dispel stereotypes and develop their understanding of how others think.

A passive or insufficiently assertive stance has been recognised as characterising some professionals' behaviour in relation to other team members. Students need to develop skills of interaction, including constructive questioning and challenging, to equip them to defend their own professional judgement and not to accept that of others without good reason.

Educational strategies which enable interaction between students provide a context in which students can develop these skills effectively. This interaction requires a focus and it seems appropriate to utilise the reality of clinical interaction to provide it.

10.3.4 Case-/scenario-based

There are many general advantages to case-/scenario-based learning as a strategy for managing patient-focused education. As long as cases are selected appropriately, the relevance of the learning to professional function is axiomatic, since it mimics the real-life situation. The exploratory, deductive nature of the learning process also mimics (and enables students to practise) the type of self-directive strategy which will be key to their continuing professional development. Students learn concepts in the professional context and, combined with the active nature of the learning process, this facilitates recall (Dolmans and Schmidt, 1996). Tope (1996), in her survey of students from a range of health and social care professions, found that patient-centred learning utilising case study was their favoured learning method.

There are specific advantages to case-/scenario-based learning when the focus is on teamworking. Students from different backgrounds tackling the problem collectively, recognise and learn to value different approaches to it and to the identification and interpretation of key factors. Hence the exploratory nature of the learning provides the opportunity for insight into

others' ways of thinking. As a strategy for learning about the teamwork agenda, it is flexible and can be tailored to the stage of development. It is equally appropriate for:

- considering the interaction of the monoprofessional team
- developing an early understanding of collaborative multiprofessional working
- considering areas of professional conflict and strategies for resolving them
- considering organisational/management issues relating to the support of teamwork.

10.3.5 Built on a model of student development

Effective learning experiences must articulate with students' stage of development. It is generally accepted that complex concepts should not be presented to beginners, but in some shared learning the endeavour to find a 'generalisable' topic relevant to several professions has not matched students' concerns at each stage of a particular programme. Staff believe that students cannot digest such material because it does not *appear* relevant at that time, rather than because it *is* too difficult or irrelevant. Curriculum content must be matched to a model of students' expected development, stage by stage.

For students following a professional programme, their development relates, in part, to their exposure to practice. Since some professions gain clinical experience much earlier than others, shared learning must take account of the variety of clinical exposure among the groups represented.

10.3.6 Ongoing throughout the education experience

No single point during students' development is most auspicious for multiprofessional education, therefore shared learning should run through the programme if it is to make a significant contribution. Each shared component needs to build upon skills and attitudes previously developed in both monoprofessional and multiprofessional contexts.

10.4 A model of multiprofessional learning

Using the six key elements above, the research team developed a model of learning (Figure 10.2) which could usefully promote the development of enhanced multiprofessional working. This proposes the development of a multiprofessional approach to working where multiprofessional groups of students explore together, through a scenario-based learning process, the fundamental requirements of working as team members. These scenarios could utilise video, paper exercises, or a combination of both.

As suggested, the model would acknowledge the process of student development. This would require awareness of student concerns such as the need for topic salience, student morale and intellectual development, the growth of their own professional perspective, and the requisite skills and knowledge needed by each profession.

Since it is proposed that the learning process would commence at the beginning of initial education, initially it would focus on the patient and professionals in general scenarios. When the student has clinical experience, the process could be based on clinical scenarios to which students bring their own experiences.

Developing a multiprofessional approach		Patient-focused learning process	Student development		
			moral and intellectual concerns	professional perspective	professional skills and knowledge
Communication What is said How it is said To whom it is said Why it is said	Multiprofessional learning set	**Preclinical** Listening to patients and carers: a video of a patient talking about themselves and their illness. What does each professional group hear and what do they think is important? Developing communication across student groups. Questioning and challenging.			
Role understanding What are the professional roles? How are they fulfilled? What is the underlying rationale for action taken? How can flexibility at role boundaries affect teamwork? Conflict around roles		**Clinical novice** Professional interaction – the ward round: students considering communication patterns and style and starting to think about professional roles.			
Team awareness What are the benefits to the patient of teamworking? What does this mean in terms of working at role boundaries? What does this mean in terms of specialist professional input to the team? How does multiprofessional working fit into the organisational context? Stages of team development **Strategies for teamwork** Developing shared structures (e.g. meetings, joint note-keeping) Developing a shared process (e.g. joint working practices) Developing a shared philosophy of practice Managing conflict	Multiprofessional clinical sets (charge with nature of current experience)	**Probationer** Paper scenarios relating to specific clinical problems: students need to bring their perspective to the problems and start to think about role boundaries and potential overlap; referral patterns. During this period, students would move from simple to complex scenarios in relation to both clinical matter and teamworking (e.g. resolution of conflict). **Practitioner**			

Figure 10.2: Developing a multiprofessional approach

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10.4.1 Content and process of multiprofessional learning

Four main areas identified from the clinical case studies need to be addressed in order to provide a comprehensive basis for student understanding of the relevance and requirements of effective teamworking:

Communication issues:

- What is said?
- How is it said?
- To whom is it said?
- Why is it said?

Role understanding:

- What are the professional roles?
- How are they practised?
- What is the underlying rationale for action taken?
- How can flexibility at role boundaries provide more effective team-working?
- Conflict around roles.

Team awareness:

- What are the benefits to the patient of working in a cohesive fashion?
- Stages in team development
- What does this mean in terms of working at the boundaries of professional roles?
- What does this mean in terms of specialist professional input to the team?
- How does multiprofessional working fit into the organisational context?

Strategies for teamwork:

- Developing shared structures, i.e. meetings, joint note-keeping
- Developing a shared process, i.e. joint working practices
- Developing a shared philosophy of practice
- Managing conflict.

During initial learning, it is suggested that it is important for the development of a multiprofessional approach to be pursued incrementally. The four areas would be introduced in sequence, with learning in relation to each area developing from, and building on preceding learning. Once introduced, each area would remain part of the learning agenda to a greater or lesser extent. Thus, complex aspects of interprofessional communication could be dealt with later, and early learning would be constantly reinforced and reapplied.

During pre-clinical learning, most students will spend time developing basic communication skills. Although this will be primarily aimed at preparing them to listen to and engage with patients, multiprofessional groupwork could expand the learning opportunities. For example, using a video of a patient talking about the experience of illness, students could practise listening and observation skills. Mixed group discussion of what they 'heard' and the value of the information would enable exploration of the different priorities of the professions, while the experience of challenging other students would begin the development of interprofessional communication skills.

As clinical novices, students will begin to understand their own and other professional roles, what they contribute, the boundaries, and the basis for decisions made by various professionals, and could also continue developing their communication skills. Again, video

information could be followed by mixed group discussion and analysis. Videos or paper scenarios could present clinical cases/scenarios in which students must identify learning tasks. At this stage students are still likely to have a monoprofessional focus; cases may be ones in which professional roles are clear and relatively independent, but still provide an opportunity to develop students' awareness of what other professions are doing.

In the probationer stage students could learn about the specific relevance of multiprofessional teamworking, primarily related to understanding its benefits to patients: in effect they would become 'team aware'. They could further explore ways in which role boundaries meet, what role overlap exists; and what skills and knowledge could be learned by all members to develop a pool of 'team understanding' to facilitate continuity of care. This could be tempered by an acknowledgement of any organisational constraints on multiprofessional working. Paper scenarios relating to clinical conditions could be presented for analysis and discussion, and at this stage students should be able to bring a wider range of experience to these group meetings.

Prior to qualification, senior students could acquire understanding of some strategies for structure and process which help to promote effective teamworking, such as regular forums for discussion. This would entail both clinical discussion and opportunities to discuss and develop team practice, i.e. sharing policies on patient management. They could also look at the development of joint note-keeping, and developing joint practice for patient care. This learning could be paper, clinical scenario-based learning, using small-group discussion. The management of conflict around roles and conflicting priorities in a team are important in preparation for practice. In order to give value to this learning, all stages should be assessed.

10.5 Shared learning: continuing education

Professional development as lifelong learning would include learning to work effectively with other professions, in a context of sustained development of the skills fostered during initial education. Shared learning in continuing education is different from that in initial education, not least in the heterogeneity of programmes offered. The range, from Masters programmes to weekend workshops, makes it impossible to generalise. Although numbers of students are still important, cohorts are smaller and there is opportunity for exchange between group members, making 'common learning' without discussion far less likely.

The research team found that the professional mix of students may look more varied than it is: while programmes may be open to a number of professions, they may recruit predominantly from one or two. Even with a mix of two professions, there may be the imbalances of numbers seen in pre-qualification programmes.

The difference between recruiting a programme from a range of professions and explicitly aiming to provide shared learning experiences is important. From the wide spectrum of continuing education programmes offered, some are multiprofessional, and may be valued as such, but have no explicit shared learning strategies, other than bringing together different professions. It could be argued that there are neglected opportunities here for interprofessional development that could be taken without changing the focus of the programme, but making better use of the advantages of a multiprofessional group. Case-focused scenarios again can prove of great benefit in enabling a richer appreciation of others' roles, and practice in negotiating differences. For example, the research team observed a group of professionals spending a day working on a complex family case scenario, which brought about interaction in a way that talking about each issue would not have done.

10.6 Whole-team development

None of the survey responses was about a higher education initiative which focused entirely on the educational development of whole teams, although there may be examples outside higher education: trust managers confirmed that their training officers include team training as part of their brief, and regional authority training programmes exist for primary health care

teams (e.g. Spratley, 1989; Dark, 1994). The managers interviewed were concerned to improve teamwork alongside the development of professional roles. Their particular concern with role boundaries must be understood in the context of the manpower shortage: nursing vacancies are the norm, and the therapy professions are spread thinly, exacerbating the need for a flexible workforce. The implication was that team members must pull together and be able to share across the gaps. Examples of researched case studies of teamwork can be used as a focus to help a team explore interpretations of teamwork, to consider the issues round roles and communication.

10.7 Facilitating multiprofessional learning

10.7.1 Classroom-based teaching

The skills to facilitate multiprofessional groups in case-based problem-solving are not easy to acquire. Linköping University listed a dozen difficulties and constraints for teachers which had arisen in their experience (Areskog, 1991). The need for time for planning, consultation, evaluation and training, plus support and cross-departmental funding were all cited, as was a lack of teaching materials. Staff felt deskilled and demotivated when they perceived themselves as 'minders' of mixed groups of students where their special professional expertise was not required; this move from teaching to taking the role of facilitator is difficult to achieve, even in monoprofessional groups.

Mhaolrúnaigh et al. (1996) evaluated educational programmes in the UK that prepare nurse, midwife and health visitor lecturers for shared learning. They found no evidence to suggest that the purpose of shared education was directly concerned with professionals working together to enhance their roles, and concluded that lecturers need preparation in greater depth to enable them to facilitate the more complex interactive models of learning. Their findings indicated that lecturers were being prepared to operate in the 'common learning' environments which characterised higher education provision. While lecturers associated positive experiences of shared learning with working in small groups, much of their shared learning teaching was in large lectures.

Many nurse and midwife lecturers have been acquiring facilitative skills over the past few years with the emphasis on reflective practice in Project 2000 Diploma programmes. As students develop clinical experience, the next step would be to move to developing reflection in multiprofessional groups.

10.7.2 Clinically-based teaching

It would be valuable to have a process which facilitates reflection on multiprofessional clinical experience in clinical areas. The challenges of training preceptors and the competing demands on their time seem considerable obstacles; however, some institutions have tried to overcome this by establishing specific clinical environments for multiprofessional education. One example is an eight-bedded orthopaedic ward at Linköping. In Britain, a London hospital has designated part of a ward as a multiprofessional learning environment. In Finland a nurse education institution has rented and converted part of a hospital as a multiprofessional learning environment. The dilemma in creating 'special' environments is whether students are being sufficiently prepared for the clinical areas they will find in practice, but it is argued that, once understandings of other professions have been gained within a clinical framework, these will never be lost and the confidence to make positive working relationships with other professionals will persist.

The ability to teach in these environments involves supervision across the range of student groups. The advantages and disadvantages of interprofessional teaching in such clinical areas was the basis of the inclusion in the research of a case study of the hospital in Finland, reported in Chapter 11. This provided a potential alternative model of multiprofessional shared learning, centred around patients in the clinical environment.

CHAPTER 11

MULTIPROFESSIONAL SUPERVISION: AN EXAMPLE IN FINLAND

Key points

- This innovative model of multiprofessional teaching and learning in a clinical environment was a rehabilitation hospital in Finland, where students of nursing, physiotherapy and occupational therapy trained.
- Despite staffing and organisational problems, the potential value of multiprofessional supervision was illustrated by video-recorded sessions showing learning points made by nursing and physiotherapy students.
- Video recording could benefit the student teaching process in multiprofessional learning.
- Staff training and supportive organisational structures for multiprofessional supervision were essential.
- All relevant professions' contribution to the multiprofessional clinical teaching session was perceived to be important.

11.1 Introduction

The clinical case studies and the exploration of multiprofessional shared learning provision in higher education demonstrated that while the rhetoric for multiprofessional learning and working may be to the foreground for government departments, policy makers, and even senior trust managers, putting them into practice is fraught with difficulties. The model proposed in Chapter 10 gave some indication of the need to think more comprehensively about the development of a multiprofessional approach, in terms of classroom agendas and their continuance in clinical placements. Where students spend between a third and half of their time in the clinical setting, the opportunity to experience the teaching input of different professional perspectives in a clinical setting has been mooted but rarely seen in Britain. Furthermore it has been recognised that those educating students in a multiprofessional fashion require specific preparation on the rationale behind such an approach. The innovation described below seemed to offer a different approach to learning from that seen in Britain, and incorporated some of these aspects.

A rehabilitation hospital was set up to offer multiprofessional training, managed via the educational institution. Its whole fresh start approach appeared to overcome some of the difficulties encountered in managing the theoretical component of a shared learning curriculum, and the impact of the organisational context on students' clinical placements. The opportunity to accomplish such a major reorientation in teaching and learning would be difficult to achieve in England, but there still seemed much to learn from such a system.

However, as with many innovations, the realities of establishing such an approach intervened and hampered the realisation of several of the original ideas. Our visits covered an evolutionary process in which, as with the British case studies, organisational and resource issues undermined the endeavour. Despite these problems, the learning environment offered real benefits for students which could be readily developed.

11.2 Background to the research

Soon after this research commenced, the Board alerted the research team to innovative work in shared learning taking place at an institute of health care in a Finnish polytechnic. The institute provided programmes of education for a number of professions including nursing, midwifery, physiotherapy and occupational therapy. It was committed to holistic care, but had

difficulty finding sufficient appropriate places for students. The director of nursing education believed that students needed a lived experience of good multiprofessional practice, and obtained the lease on a former tuberculosis hospital in a rural community half an hour's drive from the polytechnic. A 70-bed facility was set up, with a small unit providing for activities of daily living and equipment. The facility originally had three wards, providing geriatric and neuro-rehabilitation care. This was later reduced to two wards. The hospital aimed to meet the needs of the local community and provide a training environment for students.

The educational aims were to set up and sustain a learning environment for health care students which would exemplify high-quality, multiprofessional, holistic care. This would provide students with experience of working in an integrated team with other professions. To facilitate this, the hospital was managed by a principal lecturer from the institute, who worked closely with other education staff.

Students had early contact with elderly patients and those with neurological damage during the first 18 months of their education. During their time in the hospital, nursing students concentrated on topics such as hygiene, nutrition and feeding, relaxation and movement; physiotherapy students learned about mobilisation, and the OTs developed their understanding of the activities of daily living.

Two preliminary visits by the research team suggested that the curriculum model provided an innovative integration of theory and practice, while the head of the institute was keen to collaborate in the research. Evaluation of the process and outcomes of students' learning experiences was too large an undertaking, especially in view of the language difficulties. However, Finnish colleagues were interested in investigating the support and training needs of staff to enable them to supervise (act as preceptors to) multiprofessional groups in the clinical area. How did a staff member from one profession use a clinical learning opportunity for the benefit of all students in a multiprofessional group, and not just those of her/his own discipline?

The research team suspected that, as shared learning developed in Britain, there would be increasing interest in this question. The clinical case studies already indicated that the most effective teamwork involved education across professional boundaries; its development at the student level would open up thinking about how knowledge would be imparted in teamwork. Fostering multiprofessional learning among students in clinical areas is an important aspect of shared learning, and in a few places in Britain clinical supervision was already being provided by members of another profession. For example, in occupational therapy there were not enough therapists to supervise all learning areas, so other professions provided this input with a same-profession supervisor as a backstop.

11.3 Aims of the study

The original aims of studying the Finnish initiative were only partially realised. Finnish staff wanted to:

> *'Develop strategies for preceptorship within the multiprofessional team so as to support and challenge students to develop their practice within a holistic team context.'*

The British research team was to study:

- the context and the way in which these strategies were developed and tried out
- the learning environment including:
  - care provided
  - effectiveness of clinical preceptorship
  - quality of the learning experience e.g. creation of learning opportunities
  - handling of reflection on feelings and emotions brought out in the caring situation.

Ultimately, Finnish colleagues hoped to provide research descriptors for auditing an effective multiprofessional learning environment.

The objectives for the study changed when there were intimations that the hospital's situation was changing. First, one of the team's chief collaborators resigned her post, which meant that the person most involved with preceptor training and auditing would be unavailable. During the two years of the team's visits, a number of changes occurred. The realities of sustaining a hospital able to care for 70 patients impacted on the capacity to organise and implement multiprofessional initiatives. This related to more care moving into the community and supporting staff working at the hospital within a constrained budget. It was therefore decided to focus only on:

- students' experiences of learning at the hospital
- the process of multiprofessional supervision and how that shaped student understanding of other professional perspectives in relation to their own.

11.4 The context

11.4.1 The hospital structure

The hospital was situated in a wooded area near a large river. The part of the building rented by the polytechnic comprised:

- one ward holding 20 elderly patients
- one ward holding 20 neuro-rehabilitation patients
- a dining room for patients and staff
- managerial offices
- a physiotherapy department with exercise area and treatment rooms
- an occupational therapy department with kitchen and bathroom areas
- a speech and language room.

Patients from the elderly care ward participated in weekly activities which helped to provide practice in self-care and to foster their mental abilities and general well-being. Patients from the neuro-rehabilitation ward had tailored regimens of daily therapy which included one-to-one and group activities.

11.4.2 The students' clinical process

A main thrust of the Finnish endeavour was that multiprofessional teamworking would be of prime importance as an ethos for permanent staff in the hospital. This was to provide an example of effective working for students to observe and learn from. The ethos was supported by a system of joint note-keeping and regular multiprofessional case discussion meetings for permanent staff (on only one of the wards). Students were encouraged to attend the meetings and watch interventions by other professionals.

The students became members of the team during their placement, rather than maintaining supernumerary status. They were assisted in their clinical learning by the staff, and by a number of *in situ* clinical teachers drawn from the polytechnic. In this way, it was intended that all students received ongoing monoprofessional and multiprofessional supervision, allowing them to learn, and reflect on that learning, in practice; the current changes meant that this was not entirely fulfilled.

One of the research team's activities was to video-record a multiprofessional supervision session. This was later translated and interpreted separately by the physiotherapy teacher, a nurse teacher, the ex-nurse leader and a nurse student, and gave the opportunity to observe how the process might facilitate interprofessional understanding.

11.5 Multiprofessional supervision: an example of the process and issues arising

The supervision session comprised a physiotherapy teacher teaching aspects of lifting and handling a patient to: a third-year nursing student, a first-year nurse assistant student, and two final-year physiotherapy students (EU regulations now consider 'moving' to be more appropriate than 'lifting', so the Finnish use of the term 'lifting' may have been an issue of translation). The patient was a large, elderly man with a right-sided paralysis due to a stroke. His mobility was limited and he required ongoing catheterisation. The patient shared a room with another man who was present throughout most of the session.

The supervision process involved students learning how to move the man from his bed to a wheel-chair and back, then positioning him appropriately in bed. The session lasted for about two hours. In this time the physiotherapy teacher was observed to:

- assess the situation
- enquire of the patient
- question the students
- challenge their responses
- demonstrate appropriate ways of lifting and handling
- require the students to show what they had learned.

After the session, the nursing student, the physiotherapy teacher and a nurse teacher who had worked in the hospital, gave their interpretations of the session. On a later visit, a nurse teacher also commented on the video content.

Several issues were raised which showed very different professional perspectives related to certain aspects of care including:

- positioning of the bed
- the degree to which the man should move his paralysed limbs himself
- management of the catheter bag
- positioning of the professionals around, or on the patient's bed
- positioning of the patient in the bed.

As a caveat, the comments in this section on professional differences in perspectives, skills and knowledge are only examples of what was observed in this particular hospital; it is not suggested these would necessarily apply in England. However, the concepts underpinning the discussion, the way in which students could learn from other professionals in the clinical setting, remain of interest.

11.5.1 Positioning of the bed

The physiotherapy teacher introduced herself to the patient, then drew the students' attention to the position of the bed, with its head against one wall but otherwise free-standing. The teacher felt that this would compromise the patient's safety, which in turn would lead to lack of confidence:

> *'The bed is not safe. I fels angry that the nurses have left it unsafe. The client cannot assess his own safety. The bed must be against the wall to make him safe and for him to feel secure on his paralysed side. If he feels secure it will encourage him to move himself.'* (Physiotherapy teacher)

She felt that the bed should be against two walls, at the head and along one side, allowing the patient to feel that he had a surface protecting him from falling. The student nurse

disagreed and made a case for keeping the bed where it was, commenting that the patient could have cot sides attached to the bed to maintain a safe environment. He also argued that the position recommended by the PT would disrupt nursing care, since nursing a hemiplegic patient often required two nurses, and that having to work from one side only would make it difficult to move him. Finally he pointed out that:

> *'We have also to think of the other patient ... who says that the bed has changed places four times and he doesn't like it. Also the locker can't be against the wall if the bed is moved.'* (Nurse student)

This was an interesting interchange since both perspectives had some value; being right or wrong was not the case. The student had no compunction about defending the nursing decision to have the bed more free-standing; furthermore he offered a solution to the teacher's point about safety. Later, when asked where the bed was now positioned, he said:

> *'Back in the same place for the reasons that I said.'* (Nurse student)

When the ex-nurse leader watched the video, she concurred with the student and commented:

> *'If I had been there, there would have been a discussion on that.'*
> (Ex-nurse leader)

While not necessarily advocating lengthy discussions in front of patients about the correct way of managing them, the researchers were aware that it was helpful in allowing both professions to express ideas about how best to cope with patients with mobility problems. For the nursing student it was an opportunity to challenge and have his opinions heard, acknowledging his contribution to the process of care. For all students, it was an opportunity to hear an alternative interpretation of a situation, with an alternative rationale, and decisions made on the basis of that rationale.

As discussed in Chapters 4 and 5, the creation of a safe learning environment where challenges could be made were fundamental to the development of team knowledge and skills. These students appeared to perceive the environment in such a way; however, the student who spoke out appeared particularly confident and able to promote the nursing perspective well. Other students may not have been so confident, either because of temperament, lack of knowledge, or newness to the role. The presence of a nursing teacher could have ensured that not only was the nursing voice heard, but that there could have been further reflection on aspects of nursing or physiotherapy care in relation to this issue, as a result of discussion between the two teachers and their students.

11.5.2 Degree of self help to move the paralysed limb

When the man had been seated in the wheelchair by two students, the physiotherapy teacher asked whether they should have helped him to position his paralysed leg, or let him move it himself. The students suggested that the man should move the limb himself, giving the reason that the goal for the patient was to become as independent as possible. The physiotherapy teacher disagreed:

> *'Independence is very complex. If the man compensates by moving his leg with his good hand, then his brain will not develop new ways to move his paralysed leg. He must learn to establish new nerve pathways. If there is some activity in the limb then it must be encouraged to develop.'*
> (Physiotherapist teacher)

This comment described the actions a PT might take using the principles of Bobath (see Chapter 4), which were commonly held by the hospital's PTs and, the researchers were informed, nurses.

After the session the ex-nurse leader commented that, although the nurse students had learned that independence was a major goal for patients, they could not discriminate where this was most appropriately achieved: was it by leaving patients to do it themselves, or by helping them?:

> *'The students have learned the nursing principle of independence for the patient but it depends on the situation. The nurse students and the nurses wouldn't know about Bobath principles, that would be something new for them.'* (Ex-nurse leader)

However it was not acknowledged by any participants in the session, nor picked up by the ex-nurse leader, that the third-year physiotherapy students did not appear to know how to apply the Bobath principles. Since this was the students' second visit to the hospital, this may reflect the complexity of their application.

Again this episode highlights the differences between the nursing and physiotherapy perspectives and is reminiscent of the contention between therapists and some nurses in the rehabilitation case study described in Chapter 4, where nurses also emphasised a more pragmatic model of independence as the goal, while the PTs urged the use of Bobath principles to provide a better quality of movement in the development of independence. It would seem that both arguments need to be taken into consideration. In similar situations within the rehabilitation team case study, both nurses and therapists gave good reasons why a particular programme should be pursued. After the session, the nursing student made a comment which reiterated the British nurses' position:

> *'The principle is that the patient must do as much as he can. But the patient may never learn the new way.'* (Nurse student)

Since the average length of stay of this hospital's rehabilitation patients was shorter than those in the British rehabilitation unit, and bearing in mind the length of time needed to pursue quality of movement rather than more adaptive independence, the nurse's argument could be construed as the most appropriate in the circumstances.

11.5.3 Management of the catheter bag

One area highlighted by both nurse students and the nurse teacher was the lack of knowledge that the physiotherapy students showed (and her non-identification of the issue also suggests the physiotherapy teacher) of catheter care. There were several situations where the patient's catheter bag needed to be moved with him: on one occasion it was forgotten by the physiotherapy teacher, on another the physiotherapy students placed the bag on the bed and the floor, and on another occasion lifted it above the level of the patient's urinary tract.

The physiotherapy students realised their teacher's mistake and ensured that they moved the bag each time they moved the patient. After the session, this was the only aspect of catheter care which the physiotherapy teacher commented on. However, the nurse students and ex-nurse leader commented on three aspects which could have been addressed:

- the need for the greater care regarding cross infection; putting the bag on the floor or bed, and handling it on several occasions without washing the hands, would be considered risky behaviour by nurses
- lifting the bag would encourage back-flow of urine into the bladder, and could not only cause infection of the bladder but also force urine back into the ureters
- movement of the bag could be liable to cause irritation and soreness at the site of catheter entry.

To help illuminate these aspects for the PTs, both the nurse student and the ex-nurse leader acknowledged the need for the teacher to be present in the session:

'The physiotherapy students wouldn't know about this [catheter care]. I can see the usefulness of having a nurse teacher in the session.' (Nurse student)

This time, it was not that different perspectives on the same action were being given, rather that the nurses could have added to the sum of knowledge learned by the physiotherapy students about a particular intervention. Both the nursing student and the ex-nurse leader acknowledged that this information could have come from the nurse students:

'The physiotherapy students are looking to the nurse students for their expertise.' (Ex-nurse leader)

'... but a student could do that as well.' (Nurse student)

This opportunity for students to learn from each other was seen in a later session where physiotherapy students (under supervision) demonstrated lifting and moving to nurse students. Aspects of that session are described later in the chapter.

11.5.4 Professionals and the patient's private space

This aspect of the session related to differences in the ethos of the two professions and their particular knowledge. In order for the physiotherapy teacher or students to move the patient from his bed, they got onto the bed and used their feet to prop his legs while attempting to turn him. This was similar to their actions with patients in the gym when moving them on and off the plinth for exercises.

In her translation and interpretation session the physiotherapy teacher did not mention being on the patient's bed except to give the rationale for the foot positions used. However, the nursing student and the ex-nurse leader raised the issue of cross infection from the professional's clothes to the patient's bedclothes. A more important area of concern was the issue of invasion of the patient's private space:

'Nurses are taught not to sit on or stand on the patient's bed. Because first to ensure non contamination from one bed to another, and secondly in order to help the patient maintain some privacy of space in a busy ward.' (Ex-nurse leader)

She commented that nurses are taught that this should be maintained except in emergencies. She knew that for the PTs, it was:

'More important to get the positioning right rather than concentrating on maintaining respect for the patient.' (Ex-nurse leader)

While her understanding of the PTs intentions are debatable, the incident provided a glimpse of the difference in perspective between the two professions, not only in terms of their actions or of the reasons why the nurses would not get onto a patient's bed; it also gave an insight into how the term 'respect' might be interpreted. It was clear that there was no conflict for the PTs in their actions, and to have suggested that getting on the bed showed a lack of respect for the patient would undoubtedly have offended.

What might account for the difference in ethos? The nurses had greater exposure to patients over a wide range of activities, whereas the PTs performed only specific actions with them. In effect, they may not see the difference between the ward and the exercises they perform with patients in their department. In addition, although both professions handle patients in an intimate fashion, the nurses may perform the most intimate interventions. These two aspects may require symbolic distancing as argued for by the ex-nurse leader.

Whatever the reason for the differences, it would have been useful for the physiotherapy teacher and her students to have heard the nurses' rationale. Indeed it could have taken the argument for learning about other professional perspectives to a deeper level, addressing the underpinnings of the rationales for action.

11.5.5 Positioning of the patient in the bed

Later in the supervision session the patient was helped back into bed and the physiotherapy teacher noticed that his knees were swollen, and showed the students how to use foam blocks under his legs to provide support and flexion for the knees. The nursing student queried the use of these blocks, feeling that the patient looked uncomfortable.

The ex-nurse leader commented that the nursing perspective would have been vital at this point, since no caveats to this intervention had been given by the physiotherapy teacher:

> *'It is important that ... the physiotherapy teacher makes the students aware that it may not always be appropriate for the patient to have their legs raised like this. You must think about conditions such as CCF [congestive cardiac failure] as an instance where it could be damaging.'*
> (Ex-nurse leader)

She added that the swelling in the man's legs could have been related to circulatory problems since he had already sustained one stroke. However, this possible limitation to the physiotherapy intervention was not articulated by the physiotherapy teacher. Bringing together the two bodies of knowledge at this point would have been particularly relevant.

Later conversation with the nursing student showed that he was aware of the dangers related to positioning of the legs, but had already ascertained that:

> *'This patient has had a replacement aortic valve but there was no heart insufficiency.'* (Nurse student)

However, the student's promotion of the nursing perspective was not apparent when he was asked what he would do if a nurse asked why he was using such a high pillow:

> *'I would say that the physiotherapy teacher had given the instructions.'*
> (Nurse student)

This comment appears to presume an overriding of any nursing rationale in favour of the physiotherapy prescription, and suggests that having a nurse teacher in the session, would again have ensured the sharing of nursing knowledge.

11.5.6 Potential of this type of supervision for students

Nurse student feedback was that the session had been one of the most valuable and detailed inputs they had received on how to move and lift patients. One third-year student said that he had great respect for the knowledge and skill of the physiotherapy teacher and would have appreciated such a session earlier.

Overall, from the description and discussion of the observed multiprofessional supervision session, it was evident that a number of benefits *could* accrue to students and, indeed, teachers:

- the development of new skills and knowledge
- an appreciation of not only the boundaries of professional skills and knowledge as applied to a certain intervention, but also the areas of their overlap
- the development of understanding about the rationales for intervention as seen by different professionals
- the opportunity to discuss the differences in rationales
- the opportunity to develop multiprofessional decision-making related to specific actions
- the opportunity to develop confidence in contributing to learning situations
- the development of the skills of challenging in the multiprofessional context.

11.6 Changes in the hospital and their impact on student learning

Despite the session's obvious worth, it had been set up to represent an earlier teaching format used when the ex-nurse leader had worked with the physiotherapy teacher. As suggested earlier, the learning environment changed rapidly during the research. There changes to the curriculum, and to the structure and process of the hospital where students had their clinical placements. For example, at one stage, student PTs had spent several weeks on the wards acting as 'student nurses' and learning basic nursing skills, but this seemed to have disappeared from their curriculum; two students believed it should be restored. One radiography student (who was working in the hospital as a nurse) commented on how positive an experience it was for her:

> *'So far I have noticed that I have started to think differently. Now I appreciate what they do. Doctors and nurses all working together; it helps them to understand each other and communicate better.'* (Student radiographer)

In terms of structural changes in the hospital, fewer patients coming into the hospital had resulted in the loss of some permanent staff and clinical teachers: by the research team's last visit, the nursing teachers had reduced from three to two, and the physiotherapy teachers from two to one; the management structure had altered twice with consequent changes of staff. This incurred the loss of some early pioneers who had promoted multiprofessional learning and working, and several teachers and clinicians had perceived a shift away from such an approach:

> *'We are busier and the whole atmosphere has changed. It was wonderful then, but not now. I personally think that there could be more opportunities for learning, but the thinking has changed. Those who were here before knew the importance of what we were doing. Those who came later don't know that, and so don't see the importance of multiprofessional learning and teamwork.'* (Physiotherapist)

> *'At the beginning we could go further, and begin to understand each other. We began to speak the same language and have the same goals. In nursing they have their own theories, and we have our own, but we began to mix them, and develop. Later I understood that it was negative because the advances were fixed to a particular personality.'* (Physiotherapy teacher)

In this last quote the physiotherapy teacher acknowledged the power of individual personalities, rather than the activities accorded to particular roles, to maintain a particular innovation. Without people who were motivated in a certain direction, innovation could rapidly extinguish. Although in the earlier stages of the hospital's evolution, multiprofessional supervision had promoted discussion between some pioneer clinical teachers, and was perceived as an exciting means of student learning, it was now seen as a rare occurrence. More common was crossprofessional teaching; for example, PTs teaching nurses lifting and handling, and the OT teaching nurses washing and dressing in relation to the activities of daily living. However, because of pressure of work, and being new to the role, the possibilities for the OT to teach students had been reduced by the time of the last research visit.

Furthermore, it appeared that the nurses did not regularly teach student PTs or OTs specific aspects of nursing care that may have been important in rehabilitation. This had not always been the case. Earlier in the programme's development, student PTs had spent two weeks as 'nurse students' early in their training. Two third-year students felt that during this period, they had been taught basic nursing skills such as toileting and washing. Although one could argue that more could have been learned about nursing skills and knowledge, the opportunities for such learning were reduced; new physiotherapy students no longer attended the ward as nurses (nor indeed did occupational therapy students).

Practice in the hospital and teaching in the polytechnic changed with each research visit. This was very different from the intended development of a system of multiprofessional learning where students were regularly supervised by different professionals. It reflects some of the problems recognised in Britain, where budgetary concerns have resulted in reduced staffing levels, and the loss of those who pioneered particular innovations or strategies for practice.

11.6.1 Students' monoprofessional learning experiences

Despite the difficulties faced by the staff in terms of administration, it was evident that, certainly from a monoprofessional perspective, the students enjoyed some positive experiences of learning in the hospital.

The hospital also supported multiprofessional activities through various structures such as joint note-keeping and multiprofessional meetings. There appeared to be no mismatch between the concept of multiprofessional working and the reality; professionals accepted and operated in a manner congruent with collaborative working, even if roles and structures were not always clearly identifiable.

The opportunity to video-record a multiprofessional supervision session needs to be understood in context. While not a current activity, it had occurred earlier in the evolution of the multiprofessional process; the session observed was a partial reconstruction of those earlier events.

The following positive learning experiences were identified:

- Nurse and physiotherapy students always had somebody of their own profession to help them since nurse teachers covered both day-time shifts, and the physiotherapy teacher worked the same hours as the PTs. However, this was not the case for the OT student, for whom there was no permanent OT teacher; it remained for a newly-qualified OT to manage her new post and the supervision of the OT student.
- The environment was small (with a maximum of 40 patients) and geared towards accepting and helping students. Furthermore there were often a large number of nurse students available for care, so it was perceived by the students and nurse teachers that there was time for questioning members of their own and other professions. For example one morning session had 10 nursing students working with seven patients, giving opportunities for long supervision sessions on the ward. In the rehabilitation case study too, there was a small environment in which a large number of staff were accessible for reflection and discussion.
- The physiotherapy students in particular felt like members of the team. One said:

  'I get enough responsibility and they trust me, and I trust them.'
  (Physiotherapy student)

  This was echoed among the nurse students although it was only actually mentioned by a staff nurse:

  'The students are our teamworkers, so we have to work together. In the university hospital it isn't the same. They have said that they are made to stand to one side or they don't have coffee in the same place, or 'not to stand there'. But we think our students are wonderful here and we take them as part of the team.' (Nurse)

  Successful integration processes identified in the British case studies echo the emphasis in this hospital on ascribing team membership to newcomers by giving responsibility.
- The hospital was seen to have a 'non-hierarchical structure' so that discussion could readily take place between qualified professionals themselves, and between professionals and students. This applied particularly to perceptions of the medical input:

'But here it would be different. I knew the doctor who worked here two years ago. Traditionally, and in England as well people would be bowing and calling them sir. But here it is more family like.'

(Medical student currently employed as a computer technician at the hospital)

In several of the British case studies there was evidence of the constraining effect on communication evinced by members of the medical profession on other professionals. In only two case studies was this effect absent and one of these was the rehabilitation unit where the medical input was peripheral.

11.6.2 The students' multiprofessional learning experiences

Although it was possible to ascertain those positive features of the environment in the hospital, there were some detrimental aspects with regard to the issues of learning about multiprofessional perspectives of patient care, and developing multiprofessional practices in the workplace. The following were identified for student learning:

- There seemed to be no consistency in multiprofessional experiences. For example while there were opportunities for students to attend weekly multiprofessional meetings, or visit the physiotherapy and occupational therapy departments with their own patients, this was not observed by teachers or staff to be a routine part of student practice. Some students took the opportunities, others did not.
- Opportunities for crossprofessional teaching related to timing problems. If physiotherapy teachers were unavailable to run teaching sessions with nurses, the nurse teachers would supply the demonstration and discussion. In addition, because of *'heavy workload'*, the OT felt unable to teach nurses about the activities of daily living. Since each profession had its own perspective on aspects of lifting and handling for example, this lack of establishment of the practice seemed to be a wasted opportunity.
- There did not appear to be any multiprofessional teaching structure, nor regular multiprofessional teaching planning. Although promoted earlier in the hospital, this was now deemed to be less supported by management. There was no indication that nurse and physiotherapy teachers met to discuss teaching strategies, indeed the concept was met with surprise (albeit positively). One nurse teacher who had been at the hospital seven months commented after viewing the recording of the multiprofessional supervision session:

  'Sometimes physios ask us questions, but yes that [multiprofessional teaching] would be a good idea. We think of the whole person, so we could discuss that. This has been very interesting ... it has given me many ideas for the future.' (Nurse teacher)

  This may be an indication of the value of such a video as a means of inducting teaching staff into multiprofessional teaching.
- There was no established, specific preparation for all teachers who came to the hospital, either in terms of clinical teaching, or of multiprofessional teaching. A visiting lecturer had run a programme which was felt to have been a positive experience for those who attended:

  'She is so good at helping us to teach the students. We do videos and then she analyses them to look at the teaching relationship.' (Physiotherapist)

  However, attendance on this programme was only voluntary and it now seemed to be in abeyance.
- While the senior nurse teacher and the hospital manager felt they were supported by the institute, concerns were expressed by five other staff, who commented on a lack of *in-depth contact and support*. This was of concern both in terms of how well the teachers

and staff felt supported with regard to students, and in terms of promoting a multiprofessional ethos. Although there was a monthly business meeting between the head nurse teacher and physiotherapy teacher, and the school, *other* staff were unhappy with the level of contact and support:

> *'Nothing. Not from the institute.'* (Physiotherapist)

> *'Very little, and I am very sorry that there is little time.'* (Nurse teacher)

One physiotherapy teacher felt that a major part of the problem was the difference in beliefs between the polytechnic teachers and those in the hospital:

> *'In the institute I have found physiotherapy teachers who say "how can you work with nurse teachers?". They don't promote it; nursing is in one place and rehab is in another. It is only on paper.'* (Physiotherapy teacher)

This would obviously have implications for beliefs about multiprofessional practice in the hospital since teachers came from the polytechnic, and as commented on earlier, there was no specific preparation for their role in the hospital.

The crossprofessional teaching alluded to earlier was 'practised' by third-year physiotherapy students on nursing students. The following section briefly describes the process, and discusses the meaning of the session for the students and the physiotherapy teacher; and how this practice *could* provide further multiprofessional learning experiences for students.

11.7 Crossprofessional teaching: an example of students practising teaching other students

As stated above, one other video recording was made of a 'teaching', session in which physiotherapy students from the multiprofessional supervision session described above taught similar lifting and handling procedures to a new group of student nurses and care assistants.

11.7.1 The session

The hour-long session took place in the physiotherapy department, in the gymnasium. Two student PTs worked with approximately 18 student nurses and care assistants; no patients were involved. A trained PT also attended to monitor the session, which was divided into the demonstration of a number of lifting and moving techniques by the student PTs, and subsequent rehearsal by the student nurses.

With the nursing students working in groups of three, the PTs went through each demonstration, then required the nurses to practise the movement, with the nurses taking turns to be the patient.

Although the student PTs began in a fashion which shared similarities with the actions of the physiotherapy teacher in the multiprofessional supervision session, this level of interaction was not sustained. For example, they did not maintain a dialogue about the rationale for different actions, nor invite the student nurses to comment. Neither did they consistently monitor what the student nurses were doing; the nursing students gradually became less interested and more noisy.

The session closed rather abruptly, possibly due to the noise, and the student PTs simply said to the student nurses that they could ask them questions *'later on the ward, if it is necessary'*.

Because of the deterioration of the student PTs' teaching, and because the nurses' response was to become noisy and uninterested, much of the impact of this process appear to have been undermined. However it is important to determine the perceived understanding of this session in order to define ways in which this could have provided additional multiprofessional learning experiences for the students.

11.7.2 What was the meaning of the session?

The purpose of these sessions was ambiguous, and the different professionals had differing views. When the student PTs were later questioned, they saw the session as having a dual purpose: to allow them to practise teaching and impart their knowledge and skills to the nurses. The teacher saw it primarily as a teaching practice; more of a role play, with the student nurses acting as students. From general comments, and specific comments by two student nurses, it seemed that the student nurses had interpreted it as a teaching session.

Unless the purpose of these sessions was understood in the same way by all participants, the outcomes could be compromised. If, as the physiotherapy teacher perceived the situation, it was to allow the student PTs to practise their teaching skills, then one would simply expect a post-session discussion between the teacher and students to discuss the concerns and difficulties encountered (the researchers were told that this system was already in place).

If, however, one purpose was to teach nursing students about lifting and handling, one would have to question the level of consistency of the teaching methods and the resultant competencies acquired. For example, the student PTs started by describing their demonstrations, showing the movements, and encouraging the student nurses to reflect on and discuss the actions. However, this quickly reduced to a simple demonstration, repeated by the nursing students, with little or nothing said by either group, making the student PTs unable to gauge how much of the underpinning reasoning of the physiotherapy movement the student nurses had understood.

Because of the lack of consistency of monitoring the groups of student nurses, the student PTs were unable to ascertain how competently they had learned to perform the actions. Furthermore, the fact that both sessions became noisy and chaotic, hindered the student PTs from introducing a discussion time in order to bring together aspects of the demonstrations and how movements would be performed in the ward setting. Therefore the desired effect, that the nurses understood what to do, how to do it, and why they should do it in the workplace, is unlikely to have been achieved.

11.7.3 Potential benefits to the students

In spite of the probable failure of this session in terms of teaching quality, the potential for students from different professions to teach each other is worth considering. If one took the first perception of the purpose of the sessions, a means of allowing student PTs to practise their teaching skills, it could be seen as an opportunity for cross-fertilisation of ideas and understanding. This type of session was only in relation to the student PTs teaching practice (since that reflected the clinical reality of PTs teaching nurses, and not the other way around). However, this approach could be extended to include all student groups, if qualified nurses, for example, also practised in this way on the wards.

If students at a similar stage of their development came together, under the supervision of their relevant teachers, the following additional benefits could accrue:

- the opportunity for all students to explore aspects of teaching other professionals within a 'safe' environment
- the facilitation of greater understanding of the problems relating to moving and lifting without the need to 'perform' with a patient. Practising on non-patients may help students to dispel anxieties in this 'classroom' setting.

If one took the second perspective as the purpose of the sessions, that the students would actually teach each other, in the presence of their own teachers, this could allow for the following:

- the development of a pre-qualification multiprofessional teaching and learning culture, which could then transfer to practice as a trained practitioner

- the facilitation of greater confidence among pre-qualification students, to advance their own knowledge and skills to other professionals.

11.8 Conclusions

From the evidence in this chapter the research team was able to determine the potential of this multiprofessional approach to learning. Despite the difficulties which developed in the hospital, the original ideas, and the structures and processes which had evolved from those could greatly enhance students' experiences. This section discusses how the supervision and teaching practice sessions could add to the students' skills and knowledge, and what system would be required to support those approaches.

11.8.1 Use of the two multiprofessional approaches as learning experiences in the clinical setting

11.8.1.1 Multiprofessional supervision

The construction of a multiprofessional ward-based supervision session as described earlier appears to offer the potential to explore the contribution of different roles in the care process, and examine the underpinning of various role activities. However, a session like this would need to take into account patients and their needs. This was a two-hour session, and the patient was clearly tired towards the end. In order to maximise the benefits of this type of supervision, classroom sessions within the clinical setting could have taken place after the initial teaching session. This would have allowed for more detailed reflection on practice and therefore discussion around the issues raised.

Furthermore, the video recording itself could have been employed as a multiprofessional teaching tool in the classroom setting, with a larger number of students. The ability to examine and re-examine action and dialogue is a well-known teaching technique in Britain, and was already in operation in the hospital. However, in a multiprofessional context it would be particularly valuable to expose students to a number of levels of analysis of the session in order that the different professional perspectives could be examined.

Multiprofessional discussion of the video would seem to offer a bridge between the more abstract nature of theory and the practical application of skills and knowledge in the workplace.

11.8.1.2 Crossprofessional teaching practice

The 'teaching' sessions which took place in the physiotherapy department could clearly have been more structured and consistent. For example, the size of the student group was large in both instances, making it difficult for the two student PTs to monitor all the student nurses repeating the movements. A smaller group would have allowed the student PTs to monitor the student nurses more closely, and have encouraged student questions.

This student teaching session could include not only explanation and demonstration, but also time for questions, reflection and discussion. The presence of a qualified professional for each student group represented could again open up debate regarding the similarities and differences in professional perspectives, and help students to feel that they were teaching their own knowledge and skills accurately.

Both the approaches described and discussed in this chapter could provide depth and richness to skills and knowledge development for multiprofessional teamwork. However, as seen in the clinical case studies, multiprofessional practice and learning relied heavily on the context within which people were working; both in terms of organisational and group support. For students to have developed an understanding of multiprofessional team-working in this setting would require a consistent support system, elements of which are identified below.

11.8.2 The support system for multiprofessional supervision and practice

Because of the changes within the hospital, opportunities for multiprofessional learning had diminished. The following factors appear to be important for the maintenance of such a multiprofessional approach:

- Endorsement from a managerial level: managers both acknowledge the importance of such an endeavour and provide practical support. It was currently perceived that support for a multiprofessional approach to learning had diminished. The diversion of energy into managing a difficult financial situation resulted in less attention being focused on creating a multiprofessional learning context. While the value of having the institute manage the hospital can be seen as giving them control to create a good learning environment, unless teaching and management roles are separated, management problems can undermine the energies devoted to teaching.
- Teacher preparation for clinical multiprofessional supervision: multiprofessional teaching in the clinical area would need to be underpinned by preparation and support, both in terms of skills and concepts.
- The development of regular meetings between the various professions' teachers to develop structure and content for multiprofessional supervision. The British case studies clearly identified the need for dialogue about team practice as a means of establishing and promoting effective multiprofessional working.
- A well established structure which ensures that multiprofessional and crossprofessional supervision is available consistently for all student intakes.
- The understanding that all professions have an important contribution to multiprofessional supervision, so that a balance between all representative professions could be achieved. The emphasis on other professions teaching nurses was noted both in this context and in the rehabilitation case study, yet it was evident that there were elements of nursing knowledge and skills which other professionals could benefit from learning:

> *'There was no nursing input in that session and I was thinking about the background again. What was missing is "who is that person, what has happened in his life, what is the patient's situation, what is this lifting from his point of view?" I think this is important. For example "how does he experience his illness and situation?".'* (Nurse teacher)

It was clear that many staff in the hospital, and teachers who had come from the institute, perceived the importance of multiprofessional learning and practice. It is to be hoped therefore, that the setbacks experienced in the hospital will be overcome, and that the motivation to develop and re-establish previous practices will be harnessed and directed towards the institute's original goals.

CONCLUSIONS AND DEVELOPMENTAL IMPLICATIONS

12.1 Overview

The question dominating this research is 'what is shared learning preparing students *for*?' To illuminate this question, the researchers studied examples of current multiprofessional working within the NHS. The aim was to observe and analyse the realities of practice; examine the processes and problems professionals encountered in working together; and consider how students could best be prepared to practise with colleagues from other health and social care professions. At the same time data were collected about the organisation, content and teaching and learning methods of existing and planned multiprofessional learning initiatives across the country. The researchers' conclusions are that:

12.1.1 Shared learning in higher education

- Very little current provision of multiprofessional education in universities addresses interprofessional issues. There were many reasons for this, but the most fundamental was that the majority of higher education provision was never designed to meet that agenda in the first place. It had been designed to meet the legitimate organisational aims of the educational institution, centred on the economics and flexibility of provision.
- The higher education agenda promotes a pattern of multiprofessional education in which content is chosen because it is defined as 'common' across different professions (this assumption may be ill-founded) and appears to reduce duplication of teaching by accommodating students from different professions together.
- This assumption of commonality, as opposed to utilising and valuing professional differences is associated with large-group, didactic teaching rather than small-group interaction and, in initial education, pushes provision to the early part of the programme, where biological and behavioural sciences are the most frequent shared provisions.
- In continuing professional education, groups are smaller and there are opportunities for interaction but these are not always taken up when, for example, the purpose of learning together is seen as enabling professionals to receive the same information about a clinical technique or new initiative.
- The view of teaching staff was that, in general, 'teamworking' was not seen by students as an attractive option, particularly at pre-qualification level. It was viewed as 'common sense', which could be picked up later, or as unimportant compared with clinical knowledge and skills.

12.1.2 Multiprofessional teamwork

- The studies of clinical teams showed that, in teams in which there was more collaborative working, there were clear benefits for patients, carers and the team itself.
- The greater the level of collaboration across the whole team, the greater the number of incidents observed which showed:
  - *continuity and consistency of care* from professional to professional
  - a *reduction of ambiguous messages* between team members and between them and their patients/clients and carers
  - *appropriate referral*, both in terms of profession and timing

- a *wide range of knowledge* being used on which to base team decisions
- a *problem solving* approach across the team being used to determine care programmes.

- These benefits to patients were largely related to the fact that *team* knowledge and skills developed, i.e. that through role flexibility, professionals developed a wider range of skills and knowledge.
- It was clear from observing the more fragmented patterns of working, that patient care was being compromised on a regular basis.

12.1.3 Implications for education from teamwork studies

The key areas derived from the case studies for learning about teamwork were:

- Communications issues: in an interprofessional arena, including assertive, facilitative and challenging styles across status differences.
- Role understanding: of the clinican's own and of other professional roles and how these underpin action and decisions, how they are practised, and how conflict between roles can be managed.
- Team awareness: the benefits to patients, the stages in team development, working at role boundaries and fitting into the organisational context.
- Strategies for teamwork: developing a shared philosophy and joint practices and structures.

12.1.4 Trust managers

- The sample of trust managers interviewed emphasised multiskilling professionals alongside developing multiprofessional patient management plans.
- Multiskilling initiatives were progressing primarily with nurses.
- Managers identified the attitudes of the medical profession as inhibiting multiprofessional education and some team-dependent initiatives, attributing this to their culture and education.
- Managers believed that the professional bodies might sign up to the rhetoric of shared learning, but that their vested interests would lead to disputes about new interpretations of roles.

12.1.5 Professional bodies

- Professional bodies were positive about shared learning, and programme leaders did not identify them as putting up barriers to initiatives.
- Professional bodies identified the importance of focusing on groups of professionals working together at clinical level rather than those who were linked at professional body level, or in consortia or higher education institutions.

12.2 Implications for preparing students for multiprofessional practice

The finding that what is taught multiprofessionally in the majority of higher education settings is not preparing students to function collaboratively in the reality of multiprofessional teams suggests that this is in need of urgent change.

12.2.1 A model for a teamwork approach to shared learning in initial education

A suggested model of one approach to shared learning in pre-qualification education is derived from the multiprofessional working examples of the clinical case study data and their implications for education. Its key elements are:

- develops the prerequisites for teamwork
- patient/client-focused
- interactive
- case/scenario-based
- built on a model of student development
- ongoing throughout the education experience.

The clinical case studies generated four main areas addressed in the model as a basis for students' understanding of teamwork:

- communication issues
- role understanding
- team awareness
- strategies for teamwork.

These areas are developed incrementally in multiprofessional groupwork through scenario-based learning with the contributions of different professions developed through discussion. Students must see the content of the learning as clinically relevant, patient-focused, and illustrating the benefits of teamwork for patients/clients. It must also be assessed to signal its importance (groupwork assessment has a long history in education).

Problem solving, using paper scenarios or video, is not a new approach; it has been used elsewhere in learning in monoprofessional and multiprofessional settings. In the model proposed, it is not a one-off teaching method but is central to an ongoing strand of learning, which becomes more complex as students' clinical experience increases. The strand would have to be a component of a series of modules, rather than a single module, especially as some universities require all programmes to be structured around single 'short fat' modules.

The patient/client's problems or needs, and the different professional perspectives on those are the focus, not 'teamworking' *per se*. However, in the process of eliciting the perspectives and coming to a decision about appropriate care, students should be reflecting on how they are achieving the outcomes together. The model is appropriate to medical as well as to nursing and PAMs education.

The case study data, interviews with managers and the literature showed the key role that doctors have in multiprofessional teamwork and in taking forward multiprofessional developments in trusts. The *'docs have to be on board'*. The GMC (1993; 1995; 1997; 1998) and SCOPME documents demonstrate the support of the medical profession, but the case studies confirmed many situations where doctors blocked teamwork. Power and status issues within the clinical teams were seen to compromise communication. This suggests that students should address negotiation and conflict management issues as a multiprofessional group, at all stages in the education process.

12.2.2 Continuing professional education

In continuing professional education, the situation for shared learning is different from pre-qualification education in a number of ways. The range and length, from Masters programmes to one-day programmes, makes it impossible to generalise about appropriate strategies.

From the wide spectrum of programmes which recruit different professionals, some fall into the 'common learning' pattern. Where there is a small cohort, there are opportunities for interprofessional learning, which could be capitalised on to a greater extent, in order to take the learning into practice. However, this can only occur where the programme actually has a multiprofessional cohort; a number do not recruit from the professions that they are open to, and the mix is not as might appear from the prospectus.

Case-focused scenarios could again prove beneficial in enabling a meaningful understanding of others' roles and give practice at negotiating differences between roles.

12.2.3 Teacher training for shared learning

Research on the training of teachers to teach in shared learning environments has been undertaken in another Board-commissioned project (Mhaolrúnaigh et al., 1996). Their findings confirm that teachers generally do not have the opportunity in the large lectures characterising 'common learning' to promote interprofessional learning. Nor does their training enable them to pursue the more integrative, team-oriented approaches described by Gill and Ling (1995). Facilitating scenario-based groupwork requires training, whether or not it is multiprofessional. However, this kind of training is limited in availability. Furthermore, it is no good providing teacher training to facilitate interactive, multiprofessional, team-oriented, learning if the curriculum is not set up for such learning. As always, curriculum development must be synchronised with teacher development.

12.2.4 Facilitating shared learning in practice environments

Teamworking skills are learned first by students within their own profession from role models in the clinical areas. This suggests that part of the nurse preceptor's role includes taking forward the student's understanding of teamwork. The development of multiprofessional skills implies support with teamworking skills from other professionals. Some institutions have attempted this through creating 'multiprofessional, teamwork-friendly' learning environments to provide students with 'good' role models. The evidence from the Finnish case study showed the positive advantages of a dedicated learning environment and the valuable potential for interprofessional teaching. But there are also the problems of managing this and the risks of burnout for staff with too many different and demanding tasks. The 'solution' lies in fostering multiprofessional environments more generally which give students examples of collaborative practice. The case study data and the management interviews gave an indication of the difficulties, which are reviewed below.

12.3 Implications for practice environments

12.3.1 Creating a culture for interprofessionalism

There are considerable problems in creating good practice environments for teamwork. In the acute sector, organisational policies have driven working practices towards greater patient throughput by filling as many beds as possible, and staff turnover is high. Despite good intentions, therefore, the development of highly collaborative working practices may be practically impossible. The 'reality' of the stable team in relatively predictable environments may be the exception. In the community, cross-agency working has its own problems in terms of dealing with different practices and philosophies. Is the 'reality' too fraught for collaborative practices to flourish; are we expecting too much of education?

It is a mistake to think that education alone can achieve better collaborative practices. One could also argue that the clinical environment must support students by creating a culture in which interpofessional working is the norm rather than the exception. Putting individuals together and calling them a team does not necessarily lead to collaborative teamworking, as evidence from the case studies showed. Trust managers and clinicians need to develop a culture in which teams are set up as coherent, interdependent units and are sustained as such.

12.3.2 Structural inequalities

Some would argue that the political rhetoric encouraging 'joined-up' services for health and social care, will not be possible unless backed by sufficient resources. There is also the argument that inequalities in status, remuneration and training opportunities between professionals will always militate against the best intentions for developing equal partnerships. In this research, some clinicians in positions of power operated in a democratic fashion listening to advice and acting on it, despite the perceived intransigence of structural inequalities. To value listening to others can be developed through interactive education, even given the persistence of structural constraints.

12.3.3 The role of the education consortia

The role of the education consortia in purchasing, particularly with devolved budgets, is vital in steering the evolution of future programmes towards team-oriented activities which feed directly into multiprofessional working. Furthermore, they need to represent a full range of professionals, rather than the limited range reported currently.

12.4 The way forward

Curriculum change is rarely easy and straightforward. The data from curriculum managers and programme leaders have indicated many barriers to introducing multiprofessional education: concerns about 'loss' of monoprofessional time, organisational problems, difficulties with timetabling, logistics and group sizes. These barriers will remain to be overcome even if there is a shift in purpose and content towards shared learning as team-focused care. Nor will universities' concerns about economies of scale, which have driven the 'common learning' agenda, disappear. In other words, no single model or approach will meet all agendas. However, the apparent gulf between multiprofessional work in practice and what is undertaken in shared learning in higher education brings the imperative for change if the evidence of the value of collaborative teamwork to patients/clients is believed. Much of the evidence in the past has been about the problems which arise when teamwork fails (for example, in high-profile child protection cases). Similarly, lack of communication between team members, and between a team and patients and carers, is one of the most frequent causes of complaints to trusts. But more evidence is emerging about the value of collaborative teamwork. Although this was not a specific objective of this research, the benefits of this way of working were revealed because of the ongoing nature of the case study observations. Given the effort that staff in higher education must put into organising shared learning initiatives, it could be argued that directing them *specifically* towards preparation for interprofessional teamwork would provide a better long-term pay-off for students, patients/clients and carers.

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RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Shared Learning and Clinical Teamwork: new directions in education for multiprofessional practice

Carolyn Miller
Nick Ross
Marnie Freeman

This report, in the Board's series *Researching Professional Education*, has been published to make Board commissioned research readily available to policy makers, practitioners, researchers and educationalists.

Multiprofessional teamwork and shared learning are an important part of the NHS's move towards community-based and patient-focused care. *Shared Learning and Clinical Teamwork: new directions in education for multiprofessional practice* explores the:

- extent of shared learning among health and social care professions
- practice of nurses, midwives and health visitors working in multiprofessional teams
- relationship between learning outcomes and clinical effectiveness in the multiprofessional team
- implications for qualifying and post-qualification education.

The researchers carried out a detailed study including surveys, interviews, and case studies with clinical teams, higher education programme leaders, trust managers and professional bodies.

Their conclusions are of importance to all those who are involved in the development of shared learning and team working.

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QUALITY EDUCATION FOR QUALITY CARE
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research HIGHLIGHTS

The role of collaborative/shared learning in pre- and post-registration education in nursing, midwifery and health visiting

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Abstract

This project explored the role of shared learning in education by pursuing three questions: 1) What qualities and skills are needed by practitioners to work effectively in a multi-professional context? 2) What is the extent and interpretation of shared learning provision in higher education? 3) What is the fit between the knowledge and skills needed in multi-professional practice, and the teaching and learning which takes place in educational preparation?

Information on these questions was gathered from: intensive studies of six multi-professional teams; surveys of shared learning initiatives in higher education institutions; interviews with managers of NHS Trusts; and interviews with representatives of professional bodies.

The findings showed a lack of congruence between the knowledge needed to function effectively in a multi-professional team and the majority of the current education provision. It was argued that new models of shared learning education were urgently needed and an example, based on the clinical case study material, was presented.

Main Findings

1. The extent and nature of shared learning

- Very little of the current provision of multi-professional education in universities addressed inter-professional issues.
- The higher education agenda was promoting a pattern of multi-professional education in which content was chosen because it was defined as 'common' across different professions.
- This assumption of commonality was associated with large group, didactic teaching in initial education, with a common basis of biological and behavioural sciences being the most frequent shared provision.
- In continuing education, opportunities for interaction were not always taken up even though groups were smaller. This was because the purpose of having professionals learning together could be seen as simply enabling them to receive the same information.
- The view of teaching staff was that, in general, 'teamworking' was not seen by students as an attractive option for a course, particularly at pre-qualification level.

2. The problems related to the provision of shared learning

- Geographical, in that schools of medicine, nursing and PAMs could be based in different locations, and in different organisations.
- Cross organisational incompatibilities could make negotiation for course development difficult.
- Timetabling, in that finding a point at which two or more professional groups could embark on a joint learning programme required the identification of two elements: a common learning need which could be appropriately met for both groups, at the same point in time; or a point in time where each group could satisfy its own educational needs through learning from each other.
- Educational disparity at point of entry to courses.
- Differences in period of education for practice. For example, a medical programme is five years in comparison with a norm of three years for other health care professions.
- Appropriate content of topic areas because of differences in emphasis and philosophical stance between professions.
- Numerical dominance by one professional group within course sessions could mean that: the minority professional groups felt ill-served, since courses may have been tailored to meet the needs of the majority; multi-professional perspectives were not possible to explore in small group sessions.
- Timing and socialisation: views differed about whether shared learning should take place early in education in the hopes of diminishing stereotypical beliefs, or later, when professional identities had been formed and students were confident to contribute in a multi-professional arena.
- Professional bodies were not identified as creating barriers to shared learning by course leaders.

3. The organisational management agenda

- The sample of trust managers interviewed acknowledged the fact that professional roles would change substantially in response to the complexity of service delivery and therefore there was a need for greater role flexibility.
- It was accepted that the development of shared learning at pre- and post-registration level, and in-house training would be required in order to accomplish this change in emphasis towards a greater integration of professionals' practice.
- The managers emphasised multi-skilling professionals alongside developing multi-professional patient care.
- Multi-skilling initiatives were progressing primarily with nurses.
- Managers identified the attitudes of the medical profession as inhibiting multi-professional education and some team initiatives, attributing this to their culture and education.
- Managers believed that the professional bodies might sign up to the rhetoric of shared learning but they expected that there would be disputes about new interpretations of roles because of vested interests.
- The introduction of multi-professional clinical directorates, and multi-professional executive boards within trusts, had the potential to provide support for multi-professional working in terms of changing clinical practices. However, there was concern that not all professionals had sufficient representation and voice within some of these structures.
- The persistence of workforce planning as a mono-professional activity was seen to impede flexibility, especially at a time of manpower shortages, and posed a barrier to multi-professional shared learning.

4. The diversity of multi-professional teamworking

The nature of multi-professional working differed markedly across the case studies. These differences did not seem to be related to whether

the teams were hospital or community based, nor to the size of the teams. Three types of multi-professional working were identified: *integrated*, *fragmented* and *core and periphery*.

Integrated Working

This was a highly collaborative form of working seen in one case study of a neuro-rehabilitation team. The characteristics of this working were as follows:

- A highly developed shared vision of teamworking and a shared philosophy of patient care.
- All relevant team members were expected to contribute to the problem solving and decision making processes regarding their particular patients.
- Shared responsibility for team actions was considered important.
- Communication was multi-layered: information *and* knowledge sharing and the acknowledgement of professional concerns were all recognised as important for the development of effective teamwork.
- Role understanding was also multi-layered: team members felt it was important that they knew what a role comprised, how it was performed and what were the underpinning rationales for action.
- Role boundaries were flexible according to patient requirements, with team members learning skills and knowledge to ensure continuity of care.
- A pool of team skills and knowledge had developed, enabled by joint practices, such as joint note-keeping, assessment, monitoring, evaluating and therapeutic intervention.

Fragmented Working

This type of working was seen in three teams: one, an acute medical ward team was working in a very fluid and unpredictable environment; two others, a general practice and community mental health team were working in more stable environments.

- There was no shared vision of teamworking, nor a shared philosophy of patient care. Problem solving and decision making were more single profession activities, meetings between all relevant team members being rare.
- Responsibility for actions related to single profession groups.
- Communication between team members was relatively brief and related more to the giving of information rather than to the sharing of professional perspectives.
- Role understanding was superficial: team members were not able, nor in some cases willing, to develop in-depth understanding of others' roles.
- Role boundaries were actively protected by many professionals.
- Skills and knowledge remained within the individual professions.

Core and Periphery Working

This type of working was seen in two teams: diabetes and child development assessment. In these teams there was a multi-professional core who operated as a collaborative group, and other 'team members' who were more peripheral. This working was characterised by the following:

- A shared vision of teamworking and philosophy of patient care were only evident within the core group.
- The core group had developed a pool of team skills and knowledge, enabled by joint practices such as note-sharing, assessment, monitoring, evaluating and therapeutic intervention. However meetings between *all* relevant team members where these activities could occur were rare.
- Communication between team members was mixed: among those in the core group, discussion and planning were common so that information, knowledge and professional concerns could be voiced. Peripheral members did not commonly engage in these sessions; their communication being relatively brief and more related to information sharing only.
- The level of role understanding was mixed. Among core members, professionals had an in-depth understanding of each other's work and of the basis on which their actions were taken. The level of role understanding *between* the core and peripheral members and *among* peripheral members was more superficial: team members were not able, nor in some cases willing, to develop in-depth understanding of others' roles.
- Role boundaries were flexible within the core group with skills and knowledge being shared. Some peripheral members actively protected their professional roles.

5. The achievement of collaborative practice

The table opposite identifies the problems for some teams in developing whole team collaborative practices, and the ways in which collaborative practice was achieved in more integrated teams. The analysis is divided into three areas: *the organisation*, *the group*, and *the individual*.

6. Benefits to patients of collaborative working

The six case studies of clinical teams showed that, in those teams where there was more collaborative working, there were clear benefits for patients, carers and for the team itself. The greater the level

	Problems in developing collaborative practice	Ways in which collaborative practice was supported
Organisation	Fluid and unpredictable environments compromised communication and role understanding	Stability and predictability allowed the development of structures for communication
	Lack of designation to one team created tensions since allegiance was compromised with the need to prioritise work across different patient populations	Designation to the speciality encouraged the development of team allegiance and allowed professionals to focus on one group of patients
	Lack of multi-professional management structures meant that changes to team practice were difficult to achieve	Multi-professional management structure allowed for negotiation of practice change
Group	Leadership was often problematic, with leaders tending to be autocratic with or without consultation across the team	Leadership was open and responsive, encouraging all professional perspectives to be discussed
	Fragmentation of the multi-professional group prevented the formation of a shared culture. Instead practices and norms were rooted within each separate profession	The team culture ensured that: being a team player, openness of practice and honesty in communication and willingness to be role flexible were encouraged in current and new team members
	Some team environments were not considered to be 'safe' for in-depth communication and learning due to oppressive behaviours or lack of willingness to engage in these activities. This problem led to skills and knowledge remaining within each profession, thus depriving decision making of multiple perspectives	This culture fostered a safe environment for learning. In this setting, professional and team skills and knowledge developed, enhancing the decision making process
	Professional defensiveness was common due to: resistance to change, role insecurity, resource shortfalls and individual beliefs about teamwork	Professional defensiveness was limited due to: open and comprehensive discussion about team practice development, and external factors affecting the team
	Within the core and periphery teams, integration to the core of the team was difficult for two reasons: historical where founder groups had formed 'in-groups', and organisational, where access for peripheral members was constrained by policy and guideline conflicts	Selection and integration processes in the team, both formal and informal, ensured that new members were accepted rapidly
Individual	Team members did not all share beliefs about teamwork and the benefits it could bring. Motivation to work collaboratively was therefore limited	Many team members shared similar beliefs about teamwork, and its benefits. As such, motivation to work collaboratively was sustained

of collaboration across the whole team, the greater the number of incidents observed which showed:

- **continuity and consistency of care** from professional to professional.
- **a reduction of ambiguous messages** between team members and between them and their patients/clients and carers.
- **appropriate referral**, both in terms of who was referred to and the timing of that referral.
- **a wide range of knowledge** being used on which to base team decisions.
- **a problem solving approach** across the team being used to determine care programmes.

Synthesis of the Findings

1. The implications for education from the clinical settings

The following key learning areas were derived from the case studies in terms of professional learning about teamwork:

- **Communication issues** in an inter-professional arena. These include the development of facilitative and challenging styles across status differences.
- **Role understanding** of the clinician's own and of other professional roles. Consideration would need to be given to how these underpin action and decisions, how they are practised, and how conflict between roles can be managed.
- **Team awareness**. This encompasses an understanding of the benefits to patients, the stages in team development, working at role boundaries and fitting into the organisational context.
- **Strategies for teamwork**. Professionals would need to reflect on ways in which to develop a shared philosophy and the practices and structures which would facilitate collaborative working.

2. The development of a shared learning model of pre-registration education

The model was derived from the multi-professional working examples from the clinical case study data and their implications for education. Its key elements are:

- **develops the prerequisites for teamwork**
- **patient/client focused**
- **interactive**
- **case/scenario based**
- **built on a model of student development**
- **ongoing throughout the education experience**

- **The key learning areas** (communication, role understanding, team awareness, teamwork strategies) **are developed incrementally, in multi-professional group work through scenario based learning**. The contributions of different professions are developed through discussion.
- The content of the learning should be **clinically relevant for students, patient focused, and illustrating the benefits of teamwork for patients/clients**. It also needs to be assessed to signal its importance.
- **Problem solving is central to this on-going strand of learning**, and becomes more complex as students' clinical experience increases.
- Power and status issues which existed within the clinical teams, were seen to compromise **communication. This would suggest that students should address negotiation and conflict management issues as a multi-professional group**, at all stages in the education process.
- **Case focused scenarios for post-registration courses** could also prove beneficial.
- **Facilitating scenario based multi-professional group work requires training**. In addition, curriculum development has to be synchronised with teacher development.
- Part of the nurse **preceptor's role should include taking forward the student's understanding of teamwork in the clinical setting.**
- **Trusts need to consider fostering multi-professional environments more generally** which give examples to students of collaborative practice.

Methodology

The methodological approach used was based on Case Study (Simons, 1980; Merriam, 1988) and Illuminative Evaluation and Research (Parlett and Dearden, 1977; Miller, 1983). These approaches are designed to take account of the context in which people learn and work; the individuals' experiences and perceptions within that context; and the value given to the individuals being researched. In multi-professional work, individuals in one profession and across different professions, will see their work settings from their own perspectives. Discovering these perspectives was a key concern of the research. Data analysis was based on a grounded theory approach of constant comparative analysis (Glaser and Strauss, 1967; Strauss and Corbin, 1990).

The following data collection methods were used:

Case studies of multi-professional teams

Six multi-professional teams in different clinical settings were studied in depth, for 3 months each, to discover how members of the team worked together. The methods used were observation, interviews and documentary evidence. The teams were: a Diabetes Centre attached to a General Hospital; a non-fundholding General Practice; a Medical ward in a General Hospital; a Neuro-Rehabilitation Centre with a national reputation; a Community Mental Health team; a Child Development and Assessment Centre for children with learning difficulties.

Visits were made (25 days) to a health care department in a polytechnic in Finland to observe and interview staff and students in a hospital managed by the polytechnic which aimed to provide a multi-professional learning environment.

Surveys of higher education institutions

Questionnaires were sent to all higher education institutions in the UK running or planning initial or continuing education courses for health and social care professionals. 74 of the 181 contacts identified that they had programmes running, naming 206 initiatives. A second questionnaire, which requested further information about these, elicited completed details of 96 initiatives. This survey was followed up by telephone interviews with a sample of the course directors of 23 initiatives, and by visits to 7 sites to obtain more information about the planning, organisation and delivery of initiatives.

Further information

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Interviews with Trust Managers

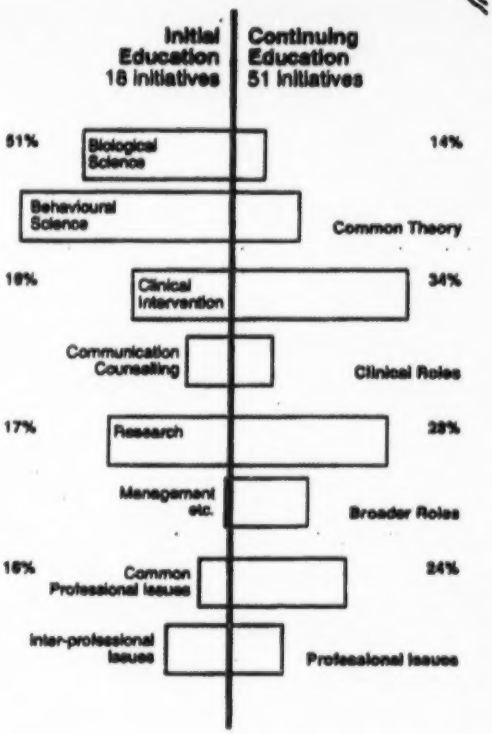
14 trust managers and senior NHS executives were interviewed about their views of multi-professional practice and education to support it.

Information from Professional Bodies

Interviews were held with representatives of a sample of professional bodies about developments in professional roles and learning between different professions. Documents and position papers were also provided and analysed.

The distribution of the content of shared learning initiatives

The diagram right shows the proportion of the identified initial and continuing education initiatives falling into each of 8 broad categories. The boxes are scaled to illustrate the proportion of each set of initiatives falling into a category, rather than the absolute number. Thus the 51% of initial education accounted for by 'Common Theory' includes four biological science courses and five behavioural science courses. In continuing education, there were two initiatives in biological science and five in behavioural science, but this constituted only 14% of the total continuing education initatives.



Details about the Project

The research was commissioned by the Board for three years, from January 1996 to December 1999. It began with surveys of shared learning in higher education and the information from these was supplemented during 1997-98 by interviews and visits to a sample of institutions. Data from trust managers and professional bodies were obtained during 1998. Given the constant changes taking place both in the NHS and in higher education, the dates at which material is collected are relevant. The clinical team case studies were carried out from June 1998 - mid 1998. The 3 month fieldwork period for each one enabled the outcomes of teamwork for patients to be observed.

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